DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center **DATE SURVEY COMPLETED: June 28, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Extended Surveys were conducted at this facility from June 8, 2022 through June 28, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 121. The survey sample totaled 55 residents. This requirement is not met as evidenced by the following: Cross refer to CMS 2567- L survey completed June 22, 2022: F600, F607, F609, F610, F641, F656, F678, F680, F684, F686, F689, F693, F695, F697, F758, F806, F812, F880, F881, F886 and F943.	A. Residents of Genesis Milford Center on 5/15/22, 5/22/22, and 5/28/22 were impacted by this deficient practice. B. All residents within the facility have the potential to be impacted by the deficient practice. C. An RCA was completed on 7/1/2022 which revealed that the facility fell below Eagle's Law on specified dates due to CNA and nurse call outs. Administrator/ Weekend Manager on Duty or designee will review scheduled hours per patient day (PPD) daily starting on 7/1/2022 to ensure the facility's compliance with the state required staffing levels. If staffing falls below 3.28 PPD, the Administrator/Schedu ler/ or Manager on Duty or designee will contact staff to come into work, offering incentives, if necessary, in order to	
3201.0			
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Sub-part B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference**		
16 Del. C. Chap. 11 §1162	Nursing staffing: (c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.		

Provider's Signature _____ Title Administrator Date 8/9/22

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	Nursing staff must be distributed in order to meet the following minimum shift ratios: RN/LPN — CNA* Day — 1 nurse per 15 res. — 1 aide per 8 res. Evening — 1:23 — 1:10 Night — 1:40 — 1:20 *or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios required under this chapter shall be (1) week. A staffing audit was conducted by the State of Delaware, Division of Long-Term Care Residents Protection on June 22, 2022. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that for three days out of 21 days, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per patient day (PPD). Findings include: Review of the facility staffing worksheets, completed and signed by the Nursing Home Administrator, revealed the following: 5/15/22 PPD = 3.20 5/22/22 PPD = 3.16 5/28/22 PPD = 3.22 Findings were reviewed during the exit conference on June 22, 2022 at 3:15 PM with E1 (NHA) and E2 (DON).	bring the facility back into compliance with Eagle's Law. D. Administrator or designee will run weekly reports on the daily HPPD to ensure the facility does not fall below Eagle's Law. The reports will be brought to the monthly QAPI meeting to be reviewed by the QAPI committee for a minimum of 3 months or until 100% compliance is achieved.	

Provider's Signature _____ Title _____ Date _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILFORD CENTER	700 MARVEL ROAD MILFORD, DE 19963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Annual and Complaint Survey and an Extended Survey was conducted at this facility from June 7, 2022 through June 28, 2022. The facility census was 121 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, Office of Long Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were cited.	E 000		
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency	E 037		8/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/22/2022

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E 037	Continued From page 1 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 2 expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 3 expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and	E 037		

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E 037	Continued From page 4 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of documents, it was determined that for two (E40 and E41) out of fifteen sampled staff members, the facility failed to ensure that staff received annual Emergency Preparedness training in the previous twelve months. Findings include: - On 11/20/19, E40 (CNA) received the most recently documented Emergency Preparedness training.	E 037	A. Employee E40 and E41 are no longer employees at Genesis Milford Center. The facility was unable to correct action. B. An initial audit was completed by the Human Resources Representative/Designee for all current staff on Emergency Preparedness Training Compliance. All current staff have the potential to be affected by the alleged deficient practice.	

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E 037	Continued From page 5 - According to facility provided documents E41 (agency CNA) received Emergency Preparedness training on 3/21/22. Additional facility provided documents failed to verify that E41 (CNA) had completed the Emergency Preparedness training as indicated. 6/22/22 - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference, beginning at 3:15 PM.	E 037	C. Root Cause Analysis was completed by an interdisciplinary team on 7/15/2022 determined not all staff were consistently provided with initial training and/or training at minimum of every year in emergency preparedness. The Administrator/Designee will re-educate all current staff in all departments on Emergency Preparedness by 8/10/2022. The facility will ensure all new staff complete Emergency Preparedness training prior to first day working in the facility and all current staff receive emergency preparedness training at minimum annually. D. The Administrator/Designee will audit all new hires and current staff to ensure compliance with emergency preparedness twice weekly for 3 weeks until compliance is achieved, then weekly for 3 weeks until compliance is achieved, and then monthly for 3 months until compliance is achieved. Results of audits will be presented to the QAPI committee for review. (Attachment 1)	
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey and Extended Survey was conducted at this facility beginning June 7, 2022 and ending June 28, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the entrance day of the survey was 121 residents. The investigative sample totaled	F 000		

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F 000	Continued From page 6 55. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; DOR - Director of Recreation; DOSS - Director of Social Services; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; NPE - Nurse Practice Educator; PDOR - Previous Director of Recreation; RD - Registered Dietician; RNC - Regional Nurse Consultant; RN - Registered Nurse; UC - Unit Clerk; UM - Unit Manager; WCN - Wound Care Nurse. Antibiotic (ABT) - medication used to treat bacterial infections; Activities of daily living (ADL's) - routine activities including eating, bathing, getting dressed, toileting, transferring, and continence; Alzheimer's Disease - brain disorder causing loss of memory, thinking and language; Ambu Bag - a medical device used to provide assisted ventilation (breathing) to people who are either not breathing or are having trouble breathing; Auscultate - to listen to body system sounds with a stethoscope; Bacteria - microscopic sized organisms, some of which cause disease; Bed Mobility - how resident moves to and from a lying position, turns side to side and positions	F 000		

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F 000	Continued From page 7 body while in bed; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0- 7: Severe impairment; BM - bowel movement; Braden Scale - a standardized assessment tool commonly used in healthcare to assess and document a resident's risk for developing pressure injuries (ulcers); Catheter - a small tube used to drain fluid; cc - unit of measure for liquids; CDC - Centers for Diesease Control and Prevention; cm (centimeter) - unit of measure in length; CMS - Centers for Medicare & Medicaid Services; Cognition - mental processes or thinking; Cognitively Impaired - mental decline including losing the ability to understand, talk or write; Constipation - difficulty in passing stool; CPR (Cardiopulmonary Resuscitation) - an emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped; D (diameter) - the distance across a circle; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; DNR (Do Not Resuscitate) - a medical order written by a doctor that instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or the patient's heart stops beating; EMR (Electronic Medical Record) - a systematized collection of patient electronically stored health information; ER - Emergency Room;	F 000		

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F 000	Continued From page 8 Eschar - dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed OR dead tissue forming a hard scab; usually black in color; Extensive Assistance - While the resident performed part of the activity over the last 7 day period, help was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff provide weight-bearing support; Foley catheter - a tubular, flexible instrument inserted and retained in the bladder by a balloon to empty urine from the bladder; FSBS (finger stick blood sugar) - a test used to check the blood sugar level; Full Code - a designation that means to intercede if a patient's heart stops beating or if the patient stops breathing; HCP - healthcare personnel; L - length; LTC - Long term care; MAR (Medication Administration Record) - list of medications to be administered; MDS Minimum Data Set - standardized assessment forms used in nursing homes; ml (milliliter) - unit of volume; Mg (milligrams - unit of weight; MS ER (Morphine Sulfate extended release) - a controlled release opioid pain medication used to treat around the clock moderate to sever pain; Necrosis / Necrotic - tissue death, usually due to interruption of blood supply or injury OR dead non-viable tissue; Offloading - removal of pressure from an area; Organisms - various types of bacteria; Oxycodone - an opioid or narcotic pain medication used to treat moderate to severe pain; Pain Scale (0-10) - the most common scale for	F 000		

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F 000	Continued From page 9	F 000		

pain. Pain is identified between zero (0) to 10, with 10 being the worst pain imaginable and 0 being no pain;
Periwound - the area immediately around the wound;
PO (per oral) - by mouth;
PRN - as needed;
Psych / Psychiatric - related to mental disorders;
Psychotropic - medication capable of affecting the mind, emotions and behavior;
Pressure Ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure;
Pulse Oximetry - measures blood oxygen saturation levels - desired range 94% to 100%;
Sacral/Sacrum - large triangular bone at base of spine;
Serous drainage - thin, clear, light yellow watery fluid found in many body cavities;
Severe Cognitive Impairment - unable to make own decisions;
Shiley - brand name of a trach tube;
Slough - yellow, tan, gray, green or brown dead tissue;
Staging (of PU's) - determination of extent of PU injury;
Tracheostomy (trach) - an opening made in the throat to assist breathing;
Tracheostomy Tube - a tube placed through a tracheostomy to provide an airway and to remove secretions from the lungs;
Tunneling - channels that extend from a wound into and through tissue or muscle;
UA (urinalysis) - an array of tests performed on urine and one of the most common methods of medical diagnosis;
Urine C & S (urine culture and sensitivity) - a microscopic study of the urine culture performed to determine the presence of pathogenic bacteria

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F 000	Continued From page 10 in patients with suspected urinary tract infection;. Undermining - skin edges have lost supporting tissue under intact skin; Urinary Tract Infection (UTI) - infection in any part of the urinary system; W - width.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other documentation, it was determined that for one (R29) out of three residents sampled for abuse, the facility failed to protect R29 from verbal abuse. Findings include: The facility policy on abuse at the time of incident, updated 4/9/21, indicated, "Centers prohibit abuse for all patients." 7/12/21 - A quarterly MDS assessment documented R29's cognition as moderately	F 600	A. Employee E46 agency contract terminated 12/17/2021 from employment at Milford Center. Resident R29 remains in the facility, was interviewed on 7/15/2022 and has not reported any other allegations of abuse. The facility was unable to correct action. B. The Director of Nursing completed the initial audit of the last 6 months of abuse allegations. All current residents have the potential to be affected by alleged	8/10/22

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F 600	Continued From page 11 impaired. An undated statement written by E47 (RN) documented, "On 12/16/21 at 11:00 PM, E46 (agency RN) was at the nurses station, said in a loud tone that she wasn't going to take care of that bitch [R29]. R29 was in her room and over heard what [E46] had (sic) said. [R29] was very upset with tears in her eyes emotional support was given." 12/17/21- R29 was interviewed by E2 (DON), who documented that R29 stated, "I could overhear (E46) at the nurses station stating that she cannot deal with that pain in the ass and that she cannot enter her room because she refuses to take care of that bitch. (R29) stated that this incident upset her very much." 12/17/21 at 3:35 PM - The facility reported an incident to the State Agency that alleged verbal abuse from E46 (agency RN) towards R29. The incident alleged the following, "Resident alleging emotional abuse on staff member. Resident stated she overheard staff member talking at the nurses station stating she cannot deal with 'that pain in the ass' and that the reason she doesn't have R29's room is because she refuses to 'take care of that bitch.'" During an interview on 6/14/22 at 12:12 PM, E47 (RN) confirmed witnessing E46's verbal abuse against R29. E47 stated, "I was down the hall and I did hear the word bitch. I went in R29's room, she was crying, she was very upset and she heard the nurse (E46) say something about she wasn't gonna take care of that bitch. I kinda stood there and I held her hand and I basically just listened and she stopped crying. I told her I was	F 600	deficient practice. C. Root Cause Analysis completed by an interdisciplinary team on 07/15/2022 determined the facility failed to protect residents from verbal abuse as the licensed nurse was unable to identify abuse accurately. The Nurse Practice Educator/Designee will re-educate all current staff in all departments on OPS 300 Abuse Prohibition with a focus on what is considered abuse by 8/10/2022. D. Director of Nursing/Designee will audit (Attachment A) 100% of reported abuse allegations twice weekly for 3 weeks until compliance achieved, then weekly for 3 weeks until compliance achieved, and then monthly for 3 months until compliance is achieved to determine if OPS 300 policy has been followed and the event was reported within the 2 hour timeframe per regulation. Results of audits will be presented to the QAPI committee for review.	

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F 600	Continued From page 12 sorry that happened." During an interview on 6/14/22 at 1:03 PM, E2 (DON) confirmed the verbal abuse allegation from E46 (agency RN) towards R29. E2 reported that E46 did not return for shifts after 12/16/21 and education on abuse was completed for all clinical staff. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON).	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, review of other facility documentation as indicated and interview, it was determined that for one (R29) out of three sampled residents for abuse, the facility failed to implement their written policy and procedure to prevent the potential for further abuse of residents and they failed to immediately report an allegation of abuse. Findings include:	F 607	A. Employee E46 agency contract terminated 12/17/2021 from employment at Milford Center. Resident R29 remains in the facility, was interviewed on 7/15/2022 and has not reported any other allegations of abuse. The facility was unable to correct action. B. The Director of Nursing completed the	8/10/22

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F 607	Continued From page 13 cross refer to F609 and F610. The facility abuse policy at the time of incident, last updated 4/9/21, indicated that "Anyone who witnesses an incident of suspected abuse is to tell the abuser to stop immediately and report the incident immediately regardless of the shift worked. The employee alleged to have committed the act of abuse will be immediately removed from duty, pending the investigation... The center will protect residents from further harm during an investigation... report allegations not later than two hours after the allegation is made." 12/17/21 3:25 PM - An allegation of abuse was reported to the State agency with an alleged incident date of 12/16/21 at 11:00 PM. During an interview on 6/14/22 at 12:12 PM, E47 (RN) confirmed that E46 (agency RN) worked the remainder of the shift on 12/16/21 with a resident assignment after an allegation of abuse was made by E46 (agency RN) about R29. During an interview on 6/14/22 at 1:03 PM, E2 (DON) confirmed the time of reporting to the State Agency as 12/17/21 at 3:25 PM. The facility failed to implement their policy and procedure when E46 (agency RN), the accused, was not immediately removed following an allegation of verbal abuse to R29. Additionally, the facility failed to implement their policy and procedure to report the allegation of abuse no later than two hours after the allegation was made. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA)	F 607	initial audit of the last 6 months of abuse allegations. All current residents have the potential to be affected by alleged deficient practice. C. Root Cause Analysis completed by an interdisciplinary team on 07/15/2022 determined the facility failed to protect residents from verbal abuse by not thoroughly implementing OPs 300 abuse and neglect policy. The Nurse Practice Educator/Designee will re-educate all current staff in all departments on OPS 300 Abuse Prohibition with a focus on accurately identifying abuse, removing the alleged abuser from duty, and reporting abuse immediately to prevent further abuse by 8/10/2022. D. Director of Nursing/Designee will audit (Attachment A) 100% of reported abuse allegations twice weekly for 3 weeks until compliance achieved, then weekly for 3 weeks until compliance achieved, and then monthly for 3 months until compliance is achieved to determine if OPS 300 policy has been followed and the event was reported within the 2 hour timeframe per regulation. Results of audits will be presented to the QAPI committee for review.	

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F 607	Continued From page 14 and E2 (DON).	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to identify an allegation of verbal abuse from staff towards one (R29) out of three	F 609	A. Employee E46 agency contract terminated 12/17/2021 from employment at Milford Center. Resident R29 remains in the facility, was interviewed on	8/10/22

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F 609	Continued From page 15 residents sampled for abuse that subsequently led to a failure to immediately report the abuse within two hours. Findings include: The facility abuse policy at the time of incident, last updated 4/9/21, indicated that "Anyone who witnesses an incident of suspected abuse is to tell the abuser to stop immediately and report the incident immediately regardless of the shift worked... report allegations not later than two hours after the allegation is made." 12/17/21 AT 3:25 PM - An incident report was submitted to the State Agency that alleged staff to resident abuse that occurred on 12/16/22 at 11:00 PM. During an interview on 6/14/22 at 12:12 PM, E47 (RN) confirmed overhearing E46 (agency RN) verbally abusing R29, but not recognizing the incident as abuse. E47 stated, "I had thought about it being abuse later. I just don't know. 75% of the time I am the Supervisor, so I may have been on that night. I did not recognize it. I would identify it now, but at the time I was really kind of unsure. I thought it best to contact the [E2 DON) and that was all the action I needed to take at the time." During an interview on 6/14/22 at 1:03 PM, E2 (DON) confirmed the time of reporting to the State Agency as 12/17/21 at 3:25 PM. E2 provided documentation that E47 (RN) was provided education on recognition of abuse and immediate reporting on 12/29/21. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON).	F 609	7/15/2022 and has not reported any other allegations of abuse. The facility was unable to correct action. B. The Director of Nursing completed the initial audit of the last 6 months of abuse allegations. All current residents have the potential to be affected by alleged deficient practice. C. Root Cause Analysis completed by an interdisciplinary team on 07/15/2022 determined the licensed nurse failed to report abuse immediately. The Nurse Practice Educator/Designee will re-educate all current staff in all departments on OPS 300 Abuse Prohibition with a focus on reporting abuse immediately to protect other residents by 8/10/2022. D. Director of Nursing/Designee will audit (Attachment A) 100% of reported abuse allegations twice weekly for 3 weeks until compliance achieved, then weekly for 3 weeks until compliance achieved, and then monthly for 3 months until compliance is achieved to determine if OPS 300 policy has been followed and the event was reported within the 2 hour timeframe per regulation. Results of audits will be presented to the QAPI committee for review.	

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to prevent further abuse of residents from an employee accused of verbal abuse against one (R29) out of three residents sampled for abuse. Findings include: cross refer F600, F607, F609 The facility abuse policy at the time of incident, last updated 4/9/21, indicated that "Anyone who witnesses an incident of suspected abuse is to tell the abuser to stop immediately... The employee alleged to have committed the act of abuse will be immediately removed from duty, pending the investigation... The center will protect residents from further harm during an	F 610	A. Employee E46 agency contract terminated 12/17/2021 from employment at Milford Center. Resident R29 remains in the facility, was interviewed on 7/15/2022 and has not reported any other allegations of abuse. The facility was unable to correct action. B. The Director of Nursing completed the initial audit of the last 6 months of abuse allegations. All current residents have the potential to be affected by alleged deficient practice. C. Root Cause Analysis completed by an interdisciplinary team on 07/15/2022 determined the facility failed to protect	8/10/22

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F 610	Continued From page 17 investigation." 12/17/21 at 3:25 PM - An incident report was submitted to the State Agency that alleged staff to resident abuse that occurred on 12/16/22 at 11:00 PM. An undated statement written by E47 (RN) documented, "On, 12/16/21 at 11:00 PM (E46-agency RN) was at the nurses station said in a loud tone that she wasn't going to take care of that bitch (R29). (R29) was in her room and heard what (E46) had (sic) said. (R29) was very upset with tears in her eyes emotional support was given." During an interview on 6/14/22 at 8:58 AM, E15 (Center Scheduling Manager) confirmed that E46 (agency RN) completed the 12/16/21 shift, then all remaining shifts were canceled. During an interview on 6/14/22 at 12:12 PM, E47 (RN) confirmed that E46 worked the remainder of the shift with a resident assignment on 12/16/21. E47 stated, "[E46 (agency RN)] continued the rest of the night with a resident assignment, but did not care for [R29], I did." Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON).	F 610	residents from verbal abuse as the alleged abuser was not removed from the facility immediately. The Nurse Practice Educator/Designee will re-educate all current staff in all departments on OPS 300 Abuse Prohibition with a focus on accurately identifying abuse and removing the alleged abuser from duty immediately to prevent further abuse by 8/10/2022. D. Director of Nursing/Designee will audit (Attachment A) 100% of reported abuse allegations twice weekly for 3 weeks until compliance achieved, then weekly for 3 weeks until compliance achieved, and then monthly for 3 months until compliance is achieved to determine if OPS 300 policy has been followed and the event was reported within the 2 hour timeframe per regulation. Results of audits will be presented to the QAPI committee for review.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		8/10/22

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F 641	Continued From page 18 by: Based on record review and interview, it was determined that, for four (R29, R67, R87 and R317) out of 39 residents sampled for MDS assessments, the facility failed to accurately complete MDS assessments reflective of the residents' status at the time of the assessment. Findings include: 1. Review of R317's clinical record revealed: 10/6/20 - An admission MDS assessment was completed for R317. The cognitive and mood patterns sections documented "not assessed." 6/22/22 10:14 AM - During an interview, E27 (MDS Coordinator) confirmed the MDS assessments cognitive and mood patterns sections documented "not assessed" and did not reflect that a resident or staff interview was completed at the time of the assessment. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON). 2. Review of R29's clinical record revealed: a. 10/12/21 - An annual MDS assessment was completed for R29, the cognitive patterns section documented that cognition was "not assessed." During an interview on 6/14/22 at 12:55 PM, E27 (MDS Coordinator) confirmed the finding and reported the paper assessment was submitted too late to incorporate into the MDS assessment. b. 4/4/22 - A quarterly MDS assessment documented R29 was receiving anticoagulant medication.	F 641	A. R317 no longer resides in the facility therefore unable to correct. R29, R67, and R87 MDS corrections completed to reflect accurate information on 7/18/22. B. All current residents MDS sections for cognition and mood patterns, anticoagulation, and preferences have the potential to be affected by the alleged deficient practice. Current residents MDS sections will be reviewed and all residents will have accurate MDS by the next assessment date. C. A root cause analysis was completed on 7/15/2022 and determined that additional education is necessary for interdisciplinary team members who complete MDS assessments as these staff members were not entering accurate information in a timely fashion. The Nurse Practice Educator/Designee will complete additional education on accuracy and timeliness of information in the MDS to all current clinical reimbursement coordinators or designees who input MDS assessments by 8/10/2022. D. The Director of Nursing/Designee will audit (Attachment B) MDS assessments for accuracy twice weekly for 3 weeks or until compliance is achieved, then weekly for 3 weeks until compliance achieved, and then monthly for 3 months until compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 641	Continued From page 19 Review of R29's April 2022 MAR's and physicians orders revealed no anticoagulant was ordered or given to R29. During an interview on 6/14/22 at 12:00 PM, E27 confirmed the error. 3. Review of R67's clinical record revealed: 5/17/22 - An annual MDS assessment was completed for R67 and the section for preferences was not completed, questions were marked as "disabled." During an interview on 6/14/22 at 11:57 AM, E27 (MDS Coordinator) confirmed the finding and reported the paper assessment was submitted too late to incorporate into the MDS assessment. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON). 4. Review of R87's clinical record revealed: 5/24/22 - An admission MDS assessment was completed for R87. The cognitive and mood patterns sections documented "not assessed." 6/10 /22 11 AM - During an interview, E9 (DOSS) confirmed that Social Services Staff completed the MDS assessment sections for cognitive and mood patterns, however, the information was not provided before the end of the assessment period on 5/24/22. 6/14/22 11:30 AM - During an interview, E27 (MDS Coordinator) confirmed the MDS assessment cognitive and mood patterns	F 641		

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F 641	Continued From page 20 sections documented "not assessed" and did not reflect that a resident or staff interview was completed at the time of the assessment. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		8/10/22

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F 656	Continued From page 21 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for two (R81 and R319) out of 39 residents sampled for care plan review, the facility failed to develop and implement a comprehensive person centered care plan. Findings include: 1. Review of R319's clinical record revealed: 7/28/21 - R319 was admitted to the facility. 8/3/21 - An admission MDS assessment documented that R319 was alert and oriented and required extensive assistance for toileting due to incontinent episodes. Review of R319's care plan revealed that the facility failed to develop and implement a comprehensive person centered care plan for incontinence. 6/21/22 11:04 AM - During an interview, E2 (DON) confirmed that R319's record lacked evidence of an incontinence care plan. 2. Review of R81's clinical records revealed the	F 656	A. Resident R319 was discharged from the facility and therefore unable to correct. R81 care plan for indwelling catheter was developed on 6/17/22. B. The Director of Nursing completed the initial audit and all current residents with indwelling catheter orders have an appropriate care plan. The Director of Nursing completed an initial audit of all residents who are incontinent and updated the care plans appropriately. All current residents with indwelling catheters and who are incontinent have potential to be affected by the alleged deficient practice. C. Root Cause Analysis was completed on 6/19/2022 and determined that R319 had orders placed for an indwelling catheter on 6/1/2022, however the care plan was not initiated in a timely fashion resulting in a 17 day delay. In addition, multiple residents with incontinence did not have the appropriate care plans in	

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F 656	Continued From page 22 following: 5/13/22 - R81 was readmitted to the facility from the hospital with an indwelling urinary catheter. 5/13/22 through 6/1/22 - The following Physician's orders were written: - 5/13/22 change Foley catheter when occluded or leaking as needed, empty catheter drainage bag at least once every eight hours when it becomes ½ to 2/3 full; every shift and as needed, perform Foley catheter care every day and evening shift and as needed - 6/1/22 Foley catheter 16 FR (French) with 10 cc balloon to bedside straight drainage. There was lack of evidence of development and implementation of a comprehensive care plan for the indwelling urinary catheter. 6/17/22 11:15 AM - During an interview, E3 (RNC) was advised of the lack of a care plan and E3 stated she would review. 6/17/22 12:39 PM - A comprehensive care plan created on 6/17/22 was provided to the Surveyor by E5 (RN UM). 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 656	place. The Nurse Practice Educator/Designee will provide education to licensed nurses who input information into the resident care plans to initiate a care plan for any resident with an indwelling catheter in a timely fashion. This will be completed by 8/10/2022. D. Director of Nursing/Designee will complete audits (Attachment C) on 100% of resident orders with indwelling catheters and current residents who are coded as incontinent on admission on MDS to ensure plan of care is initiated and in place. Audits will be conducted twice weekly for 3 weeks or until compliance is achieved, then weekly for 3 weeks or until compliance is achieved, and then monthly for 3 months or until substantial compliance is achieved. Results of audits will be presented to the QAPI committee for review.	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to	F 678		8/10/22

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F 678	Continued From page 23 related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation as indicated, it was determined that for three (R37, R89 and R105) out of 25 initial pool residents reviewed for Advance Directives in relation to code status, the facility failed to ensure that code status' were accurate and congruent in all facility documents. For R37, his electronic medical records (EMR) failed to match the Resident Healthcare Instructions Checklist filed in the advance directive tab of the paper chart located in the Memory Care nursing station. For two residents (R89 and R105), their EMRs failed to match the staff generated shift report that R89's staff nurse in the Memory Care unit and R105's staff nurse in the East unit use as a reference in determining the code status. Furthermore, interviews with multiple staff revealed inconsistencies regarding where to find the back up information on each resident's code status in the event of an EMR system failure. The discrepancy put R37, R89 and R105 at immediate jeopardy (IJ) of a serious adverse outcome by not having a confirmed, accurate code status in the event of a medical emergency. The inaccuracies could result in CPR being administered to a resident requesting to not be resuscitated (DNR) or CPR not being performed on a resident requesting that all life sustaining measures be performed (Full Code). The IJ was identified on 6/9/22 at 4:00 PM and was abated on 6/10/22 at 3:42 PM. Findings include: The facility policy on Code Status Orders, dated 1/31/20, indicated that "Code status	F 678	A. Immediate action was taken to ensure R37, R89, and R105 have accurate and congruent code status documents on 6/10/2022. B. An audit was conducted on 6/10/2022 to ensure all current residents had accurate and congruent code status documents. All current residents in the facility have the potential to be affected by the deficient practice. C. A root cause analysis was completed on 6/10/2022. It was identified that all current residents had accurate electronic code status orders in the point click care electronic system. However, a minimal amount of licensed nursing staff were referring to nursing report sheets for code status instead of the required facility generated report sheet which reflect current accurate code status as per orders. The Nurse Practice Educator/Designee provided education to all current licensed nurses on confirming code status and shift to shift report procedure, and that red bands on residents wrists do not signify DNR on 6/10/2022. The Nurse Practice Educator/Designee will educate all additional and newly hired nursing staff prior to the start of their first shift. D. The Director of Nursing/Designee will audit (Attachment D) all licensed nurses	

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F 678	Continued From page 24 communicates to the clinical staff whether the patient desires cardiopulmonary resuscitation (CPR) in the event of cardiopulmonary arrest. Patient identification mechanisms and information about each patient's code status (Full code vs. Do Not Resuscitate (DNR)) will be easily accessible to the clinical staff for all patients...To ensure that the patient's desired resuscitation wishes are documented in the medical record." 1. Review of R37's clinical records revealed the following: 5/5/22 - R37 had an active physician's order for DNR. 6/8/22 at 4:05 PM - Review of R37's code status was displayed in the EMR as DNR. 6/9/22 at 9:40 AM - During an interview, E35 (LPN) stated that the facility provides a copy of the signed advance directive with the code status to the receiving provider. E35 further stated that the documents were usually scanned into the EMR and added, "...if we can't find a scanned signed copy of the code status in the (EMR), we look at the chart and print copies from the documents filed in the advance directive tab." 6/9/22 at 9:42 AM - Review of R37's paper chart revealed an undated Resident Healthcare Instructions Checklist filed in the advance directive tab that documented "Attempt CPR." 6/9/22 at 9:43 AM - When asked about the discrepancy of R37's code status from the EMR physician's order for DNR compared to the record found in the paper chart documenting "Attempt CPR", E35 (LPN) confirmed the code status in	F 678	for completion of code status education and use of facility generated report sheets to match resident code status orders 3 times a week for 3 weeks or until compliance achieved, then weekly for 3 weeks or until compliance achieved, and then monthly for 3 months or until compliance is achieved. Results of audits will be presented to the QAPI committee for review and.	

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F 678	Continued From page 25 the paper chart was not updated. R37's code status was recorded in two different documents that did not match. 2. Review of R89's clinical records revealed the following: 11/23/21 - R89 had an active physician's order for DNR. 6/8/22 at 3:45 PM - Review of R89's electronic physician's order for code status was displayed in the EMR as DNR. 6/9/22 at 9:40 AM - During an interview, E35 (LPN) stated that in the event that a resident becomes unresponsive, she will first determine the code status by checking the shift report sheet. E35 stated, "It has the residents' updated code status. The night nurse in the Memory Unit checks and updates the resident's code status for any status changes in the staff generated shift report." 6/9/22 at 2:00 PM - Review of the Memory Care Unit's shift report sheet documented R89's code status as a Full Code. R89's code status was recorded in two different documents that did not match. 3. Review of R105's clinical records revealed the following: 5/19/22 - An order for DNR was written for R105. 6/8/22 at 2:45 PM - Review of R105's EMR documented the residents code status as DNR.	F 678		

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F 678	Continued From page 26 During an interview on 6/8/22 at 2:52 PM, E32 (RN) stated the resident's code status was located at the "front of chart and in the computer. I can also see it on the MAR, in front of the chart and on the assignment sheet too." During an interview on 6/8/22 at 2:54 PM, E45 (LPN) stated residents' code statuses were located "In the computer, its right there on the dashboard [EMR] and then in the beginning of the chart." E45 stated she would not look at the resident assignment sheets because "they may not be up to date." 6/8/22 2:55 PM- Review of the East unit's resident assignment sheets for nurses documented R105 as having a code status of "full code." 6/8/22 3:33 PM- Review of the undated resident healthcare instructions checklist documented R105 as a DNR code status, reviewed with E43 (MD). The checklist was filed in the advance directives tab in the chart. During an interview on 6/9/22 at 3:36 PM, E6 (RN UM) was asked the locations of resident code status information. E6 answered "Under their name and picture in the EMR, physicians orders and front of paper chart." E6 then explained under emergent conditions, E6 "would look it up depending on where I was in the building, whatever was closest." E6 confirmed R105's code status as a DNR using the EMR. When asked where else staff could locate resident code status and information, E6 stated, "The healthcare instruction checklist and staff can use the assignment sheets." E6 was shown the	F 678		

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F 678	Continued From page 27 discrepancy between R105's EMR that documented the resident as a DNR and the resident assignment sheet which documented the resident as a full code. R6 stated, "That has not been updated... the nurses are supposed to update them, I would have to ask them how often they update them. There is one that can be generated from the software. I don't work the cart, but this (the resident assignment sheet) is what nurses use." E6 then reported she would update the resident assignment list to reflect R105's ordered code status as well as review the rest of the residents on the assignment sheet. 6/9/22 4:00 PM - E3 (RNC) and E1 (NHA) were made aware of the above findings. 6/9/22 at 3:20 PM - In an interview, E36 (LPN) stated that when a resident becomes unresponsive, she would check the resident's profile and code staus order in the EMR. E36 also stated that the code status is documented in the nurse shift report (referring to the staff generated shift report). In the event that the EMR is not available, E36 stated that she would go to the chart and check the advance directive tab for the signed copy of the residents code status. 6/9/22 at 4:00 PM - E1 (NHA) and E3 (RNC) were notified by the survey team that during the initial pool record review, it was identified that three residents (R37, R89 and R105) did not have consistent advance directives related to code status in their medical records and that nursing staff were unable to consistently state where the accurate code status could be found. 6/9/22 at 5:58 PM - In an interview, E1 reported that an abatement plan had been initiated and	F 678		

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F 678	Continued From page 28 that facility - wide education related to resident emergency code status, location of code status, and protocol for determining code status was being implemented. 6/9/22 at 7:36 PM - E1 confirmed that an audit was completed of all residents to ensure accurate code status'. 6/9/22 at 10:24 AM - E1 provided the survey team with an action plan for continued training. 6/10/22 at 3:42 PM - E1 provided the survey team with updated policies and evidence of licensed staff education. The survey team through interview and record review confirmed: -advanced directives/code status for all residents were accurate and congruent in all facility documents. -facility nursing staff were able to articulate how to find the code status for all residents. -staff education was conducted and was ongoing for staff prior to working. Abatement of the IJ was called at 3:42 PM on 6/10/22. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 6/22/22, beginning at 3:15 PM.	F 678		
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an	F 680		8/10/22

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F 680	Continued From page 29 activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the activities program was directed by a qualified professional from 9/18/21 to 6/16/22, approximately nine (9) months. Findings include: 6/14/22 2:00 PM - During an interview with E23 (Director of Recreation - DOR), E23 stated she began her employment as the DOR on 11/2/21 and until approximately one month ago, a Regional DOR was providing guidance to E23, however, E23 confirmed that she was responsible for overseeing the facility's activity program, which included completing each resident's activity preferences in various MDS assessments, conducting quarterly activity participation reviews for each resident, managing the activity program calendars, writing progress notes in resident's clinical records and participating in care planning for each resident. E23 confirmed that she	F 680	A. E23 received art therapy certification on 6/16/2022 prior to the completion of the survey. B. All current residents who attend activities have the potential to be affected by the alleged deficient practice C. Root Cause Analysis was completed on 6/16/2022 and determined the facility failed to ensure that the Director of Recreation had all appropriate certifications upon hire. D. Administrator/Designee will ensure appropriate certification is obtained upon hire of any newly hired Director of Recreation (Attachment E). Results of audits will be presented to the QAPI committee for review and recommendation.	

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F 680	Continued From page 30 currently was not licensed or registered as an activities professional. 6/15/22 approximately 3:30 PM - During an interview with E1 (NHA), the Surveyor requested evidence of E23's meeting the qualifications as an activity professional. In addition, the dates of employment for E48 (PDOR) and E23 were requested. 6/16/22 10:00 AM - The Surveyor was provided employment dates for both E57 and E23. E57's last date as the DOR was 9/17/21 and E23's first day as the DOR was 11/2/21. 6/17/22 9:45 AM - An interview with E1 (NHA) was conducted and E1 provided evidence that E23 completed a Certificate of Art Therapy on 6/16/22, thus, meeting the qualification as an activity professional as of 6/16/22. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 and E2 (DON).	F 680		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		8/10/22

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F 684	Continued From page 31 Based on interview and record review, it was determined that the facility failed to ensure that two (2) residents received treatment and care in accordance with the residents comprehensive person-centered care plan. For two (R75 and R87) out of seven (7) residents reviewed for potential for constipation, the facility failed to assess the residents for signs or symptoms of constipation and administer medications as ordered for no bowel movement (BM) after three (3) days. In addition, for one (R75) out of one three (3) residents reviewed for urinary catheter/UTI, the facility failed to ensure that an appropriate antibiotic was administered to treat R75's urinary tract infection (UTI) and the facility failed to ensure timely scheduling of an appointment for recurrent UTI. Findings include: 1. Review of R87's clinical records revealed: 5/17/22 - R87 was admitted to the facility. 5/17/22 - The following Physician's orders were written for three laxative medications: - Milk of Magnesia as needed for constipation, give at bedtime if no BM in three days. - Dulcolax Suppository as needed for constipation if no result from Milk of Magnesia by next shift. - Fleet Enema as needed for constipation if no result from Dulcolax within 2 hours. If no result from Fleet enema call MD/advanced practice provider for further orders. 5/17/22 (Most recent revision date of 6/10/22) - A care plan stated that R87 exhibited or was at risk for gastrointestinal symptoms or complications related to constipation and the goal was that the resident would not have complications. Interventions included to monitor and record BMs,	F 684	A. R75 and R87 were assessed for constipation on 7/15/2022. No signs or symptoms of constipation noted and both residents have not been 3 days without bowel movements. Unable to correct previous deficient practice. R75 was placed on appropriate antibiotic therapy per culture and sensitivity on 5/8/22. R75 scheduled for urogynecology appointment on 8/1/2022. Appointment was made on 6/17/22 prior to the completion of the survey. B. An audit was completed on all current residents who have not had a bowel movement in 3 days, are awaiting culture and sensitivity results, and who have orders for appointments. All current residents have the potential to be affected by alleged deficient practice. Root cause analysis completed on 7/15/22 identified that licensed nursing staff did not timely review chart alerts on the occasions identified during the survey for residents who were 3 days with no documented bowel movement which affected the timing of the administration of bowel protocol medications on these occasions. C. Root cause analysis completed on 7/15/22 identified R75 was not placed on the appropriate sensitive antibiotic in a timely fashion as a result of the staff not following up on pending laboratory results. The NPE/Designee will provide additional education to all licensed nurses on the process for proactive review in Point Click Care specifically for chart alerts for all	

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F 684	Continued From page 32 encourage resident to consume all fluids during meals, document the frequency and consistency of stools, and offer and encourage fluids of choice. 5/26/22 through 5/31/22 - CNA documentation titled "Toilet/Bowel/Bladder" revealed that R87 had a large BM on 5/26/22 at 2:14 PM and the next BM was a small BM on 5/31/22 4:00 PM. There was lack of evidence that the facility assessed for signs or symptoms of constipation and/or administered medications as ordered for no BM in three (3) days. 2. Review of R75's clinical records revealed: a. 2/10/22 - R75 was admitted to the facility. 2/10/22 - The following Physician's orders were written for three laxative medications: - Milk of Magnesia as needed for constipation, give at bedtime if no BM in three days. - Dulcolax Suppository as needed for constipation if no result from Milk of Magnesia by next shift. - Fleet Enema as needed for constipation if no result from Dulcolax within 2 hours. If no result from Fleet enema call MD/advanced practice provider for further orders. 2/10/22 - A care plan stated that R75 exhibited or was at risk for gastrointestinal symptoms or complications related to constipation, nausea/vomiting and the goal was that R75 would pass a soft formed stool every 3 days. Interventions included to administer medications as ordered and observe for effectiveness and side effects and report to MD as indicated, monitor and record BMs, provide bowel regimen, utilize pharmacological agents as appropriate,	F 684	residents each shift and administration of medications provided according to bowel regimen protocol by 8/10/2022. The NPE/Designee will provide additional education to management staff and medical personnel to check DHIN every 24 hours for culture and sensitivity results pending from a hospitalization and call the hospital on day 3 if no results are received by 8/10/2022. The additional education will include an objective to document the routine 24 hour check in the medical record, even if no result is available. The NPE/Designee will provide additional education to the unit clerk on how to run ancillary order reports daily and discuss during morning meetings by 8/10/2022. D. The Director of Nursing/Designee will complete an audit (Attachment F) of residents with chart alerts for not having a bowel movement within 3 days daily for 7 days or until 100% compliance is achieved, then weekly for 3 weeks or until 100% compliance is achieved, and then monthly for 3 months until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review. The Director of Nursing/Designee will complete an audit (Attachment G) of residents who are currently on antibiotic therapy and/or awaiting culture and sensitivity laboratory results daily for 7 days or until 100% compliance is achieved, then weekly for 3 weeks or until 100% compliance is achieved, and then monthly for 3 months until 100% compliance is achieved. Results of audits will be presented to the	

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F 684	Continued From page 33 i.e. stool softeners, laxatives, etc, document effectiveness, assess for signs and symptoms of constipation, i.e. nausea, vomiting, headache, abdominal distention and cramping 3/1/22 through 6/15/22- CNA documentation titled "Toilet/Bowel/Bladder" was provided by E2 (DON) which revealed: - 3/27/22 at 10:31 PM, R75 had a large BM and the next BM was documented on 4/3/22 at 10:53 PM. There was lack of evidence that the facility assessed for signs or symptoms of constipation and/or administered medications as ordered for no BM in three (3) days. - 5/31/22 at 2:59 PM, R75 had a large BM and the next BM was documented on 6/4/22 at 2:48 PM. There was lack of evidence that the facility assessed for signs or symptoms of constipation and/or administered medications as ordered for no BM in three (3) days. 6/15/22 12:30 PM - During an interview with E7 (RN), E7 stated that a resident's BM activity was communicated during the nursing shift to shift report. E7 also stated that the computer system used for resident care documentation has a clinical report titled "Alert Listing" which describes the date of the last BM for each of the facility's residents. E7 stated that the ordered bowel protocol should be initiated if a resident does not have a bowel movement in three days 6/17/22 10:45 - During an interview, E5 (RN UM) confirmed there were no bowel protocol interventions for R75 during the time periods 3/28/22- 4/2/22 and 6/1/22-6/3/22. Cross-refer F881	F 684	QAPI committee for review. The Director of Nursing/Designee will complete an audit (Attachment H) of all residents needing follow up appointments scheduled daily for 7 days or until 100% compliance is achieved, then weekly for 3 weeks or until 100% compliance is achieved, and then monthly for 3 months until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 684	Continued From page 34 b. 2/10/22 - R75 was admitted to the facility. 4/30/22 3:55 PM - A Nursing Progress Note stated R75 complained of being dizzy and a Physician's order was obtained to transfer R75 to the emergency room (ER). 4/30/22 10:15 PM - The Nursing Progress Note stated R75 returned from the ER with a diagnosis of UTI. 4/30/22 - The ER visit summary listed a diagnosis of UTI and a progressive urinalysis (UA) was initiated with results of the culture and sensitivity (C&S) pending. R75 was ordered Augmentin (an antibiotic) for 10 days. 5/3/22 8:17 AM - The result of the UA/C&S was requested by the Surveyor during the survey and provided by E2 (DON) on 6/15/22 at 12:15 PM. The UA/C&S results indicated that Augmentin was not on the list of antibiotics that was sensitive to the organism to treat R75's UTI. 5/3/22 through 5/9/22 - Review of the MAR revealed R75 was administered 10 doses of Augmentin, an antibiotic which was not on the C&S report as being sensitive to treat R75's UTI. 5/8/22 - A Physician's order was written by E43 (MD) for Cefdinir (a different antibiotic and sensitive to R75's UTI) by mouth for 10 days. 5/9/22 - A Progress Note by E4 (NP) stated, "...Patient report (sic) burning with urination is slowly improving. Urine sensitivity results received and no sensitivity to Augmentin. Stop Augmentin twice daily for 10 days, start Cefdinir 300 mg twice daily for 10 days. Will continue to	F 684		

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F 684	Continued From page 35 monitor closely." 6/7/22 - A Physician order was written for a urogynecology consultation for recurrent UTI and to please schedule the consult. There was lack of evidence that the urogynecology consultation was scheduled until inquiry by the Surveyor on 6/13/22 with E5 (RN UM) at approximately 12:30 PM. 6/17/22 12:01 PM - During an interview with E28 (UC) to inquire about the urogynecology consultation, E28 stated that R75 has an appointment scheduled for 8/1/22. There was a delay of approximately six (6) days in scheduling the above consultation. . 6/21/22 11:45 AM - During an interview with E4 (NP), E4 stated a Physician from the hospital called E43 (MD) on 5/8/22 to report the result of the 4/30/22 UA/C&S and E43 discontinued the Augmentin and ordered Cedifnir on 5/8/22. E4 confirmed that if the results were available to E4 on 5/3/22, the Augmentin would have been discontinued and the treatment plan would have been reevaluated at that time. Due to the above failure to obtain the results of the urine C&S timely, R75 continued to receive an inappropriate antibiotic (Augmentin) for 6 days and there was a delay in starting an antibiotic that was sensitive to the bacteria. In addition, there was a delay in arranging for a urogyenocology consultation due to the order not being carried out for five (5) days.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		8/10/22

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F 686	Continued From page 36 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, review of the clinical record, review of the facility's guideline and review of professional clinical resources as indicated, it was determined that for one (F87) out of five (5) sampled residents for pressure ulcer (PU) reviews, the facility failed to ensure that the resident received the necessary treatment and services, consistent with professional standards of practice, to prevent new pressure ulcers (PU's) from developing. R87 was admitted to the facility with no PU, was assessed as being at risk for the development of PU's, yet the facility failed to develop and implement preventative measures, including an individualized turning and repositioning (T&R) program that resulted in R87 acquiring an avoidable unstageable PU of the sacrum on 6/1/22. Findings include: According to the National Pressure Ulcer Advisory Panel (April 2016), the stages of pressure injuries/ulcers (categorization system used to	F 686	A. Unable to correct. A turning and repositioning program was implemented on R87 on 6/1/2022. B. The Director of Nursing completed an audit of all current residents' braden scores and ensured any resident with a score of 18 or below was on an appropriate turning and repositioning program. All residents with a Braden score of mild risk have the potential to be affected by the alleged deficient practice. C. Root Cause Analysis was completed on 7/18/22 determined that residents with a braden score or 18 or lower, (which indicates mild, moderate or severe risk for skin breakdown) did not consistently have a turning and repositioning program implemented upon admission. The Nurse Practice Educator/Designee will provide	

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F 686	Continued From page 37 describe the severity of PUs) included: Stage III (3) - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin. Undermining may occur. Stage IV (4) - ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints. Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage is more severe than slough in the wound bed). Review of the facility's undated guidelines revealed the following: "Pressure Ulcer Prevention Guidelines. Basic Prevention Interventions for all patients at risk. Perform daily observation of the skin... Apply moisturizer daily. Apply moisture barrier to high risk areas such as heels, elbows, etc... Encourage frequent repositioning/weight shifting... Utilize pressure redistributing surface... Risk Factor Impaired/Decreased mobility/function. Example of Intervention... Individualized positioning and repositioning schedule... refer to rehabilitation for seating/positioning/interventions to increase mobility and function... turning and repositioning plans are implemented regardless of bed surface... Guidelines: Turning and Repositioning... Provide turning and repositioning to individuals at risk for pressure ulcers; specifically, those who have impaired mobility and/or impaired sensation. Turning and repositioning plans are implemented regardless of bed surface. Schedules are based on individual needs, risks, tissue tolerance...".	F 686	additional education on skin care interventions for identified residents who have a braden score of 18 or lower. In addition, the licensed nurse will implement a turning and repositioning schedule for all residents with impaired mobility and a braden score of 18 or lower on admission by 8/10/2022. D. The Director of Nursing/Designee will complete an audit on all current residents with a braden score of (15-18) which indicates mild risk of skin breakdown to ensure a turning and repositioning program is initiated. The Director of Nursing/Designee will then audit (Attachment I) the braden scores of all residents newly admitted to the facility 3 times a week for 3 weeks or until 100% compliance is achieved, then weekly for 3 weeks or until 100% compliance is achieved, and then monthly for 3 months until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 686	Continued From page 38 Cross-refer F697 Review of R87's clinical records revealed the following: 5/17/22 3:24 PM - A Nursing Documentation Note (Progress Note) documented that R87 was admitted for pain management and therapy. The Admission Nursing Skin Assessment documented the presence of three (3) small scabs on top of the right foot, however, R87 was not admitted with a PU. R87 was documented as having pain during T&R with a pain rating of 10 and at rest, a 7 (Pain Scale of zero (0) to 10 with 0 being no pain and 10 being the worst pain imaginable). 5/17/22 - The care plan stated that R87 required assistance with ADLs and interventions included one staff person to provide extensive assistance with bed mobility. 5/17/22 - The Braden Scale (completed by facility Nurse's) was completed with a score of 15 or that R87 was at mild risk for the development of PU's. There was lack of evidence that the facility developed and initiated an individualized T&R program when R87 was assessed as being at risk for the development of a PU. 5/17/22 through 5/24/22 - CNA "Documentation Survey Report" stated R87 required total assistance of staff on two (2) out of 17 shifts documented, required extensive assistance of staff for 13 out of 17 shifts and limited assitance of staff for two (2) out of 17 shifts.	F 686		

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F 686	Continued From page 39 5/24/22 - A weekly skin check documented no new skin injury/wounds. 5/24/22 - The 5 day Admission MDS Assessment documented that R87 required extensive assistance of two plus staff for bed mobility and transfers, required extensive assistance of one person for toileting, was frequently incontinent of urine and bowel, had no PU's, and R87 was not on a T&R program. 5/24/22 - R87's Braden score was 16 or at mild risk for the development of PU's. 5/30/22 (initial date and revised on 6/8/22) - A care plan stated that R87 was at risk for skin breakdown related to assistance needed with bed mobility and urinary incontinence. Resident has an actual unstageable pressure ulcer (identified on 6/1/22) that included the following interventions: - Pat (do not rub) skin when drying. - Provide preventative skin care (i.e. lotions, barrier creams as ordered). - Assist resident in turning and repositioning every 2 hours (intervention was created on 6/1/22). - Observe skin condition daily with ADL care and report abnormalities. - Offload/float heels while in bed with use of pillows (created on 6/1/22). - Obtain RD consult (created on 6/1/22). - Pressure redistribution surface to bed per guideline. 5/17/22 through 5/31/22 - CNA documentation stated that the following interventions were completed for the prevention of skin breakdown: - Preventative skin care - float heels with use of pillows in bed: For 13 out of 42 shifts, there was	F 686		

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F 686	Continued From page 40 lack of evidence that this intervention was implemented. - Preventative skin care - lotion/cream apply barrier cream to buttocks with incontinence care: For 13 out of 42 shifts, there was lack of evidence that this intervention was implemented. There was no evidence that an individualized T&R plan was developed and implemented although R87 was assessed for being at risk for the development of PU's. 5/31/22 - R87's Braden score was 15 or at mild risk for the development of PU's. 6/1/22 1:58 PM - A Wound Assessment by E24 (RN WCN) documented a sacral unstageable PU measuring 1.5 cm L x 3 cm W x 0.1 cm D with 20% granulation, 60% slough, and 20% necrotic. The wound was reported by the CNA who was providing personal care to R87. The NP was notified, care plan updated and orders updated. E24 instructed R87 on the importance of repositioning every two (2) hours to assist with wound healing and to prevent further skin breakdown and R87 verbalized understanding. 6/2/22 - CNA documentation stated that a new intervention to assist R87 to T&R and check skin every 2 hours was initiated, however, there was lack of evidence that this intervention was completed. 6/2/22 2:00 AM - A Nursing Progress Note stated, "...sacral wound dressing in place...Resident refused to stay on side even after education. C/O (complaint of) anxiety not relieved by non pharmacological measures...".	F 686		

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F 686	Continued From page 41 6/2/22 8:00 AM - A Nursing Progress Note stated, "...treatment completed to sacrum (sic) wound. turned and repositioned every 2 hours side to side...". 6/3/22 -6/5/22 - CNA documentation revealed that R87 was assisted to T&R and skin was checked every 2 hours as ordered. 6/8/22 12:40 PM - An interview with E24 (RN WCN) revealed that she performed weekly wound rounds and reported any updates to E2 (DON) and the Medical Practitioner. E24 stated that R87's new skin impairment was identified by the CNA providing care to R87 on 6/1/22, however, E24 did not recall the name of the CNA. 6/10/22 3:30 PM - An interview with E24 in the presence of E3 (RNC) was conducted. E24 stated that she recalled initially when R87 was admitted to the facility, R87 was able to T&R independently, however, R87 had difficulty due to pain in the lower part of her body. E3 related that according to the MDS (dated 5/24/22), R87 required assistance of staff with bed mobility. The Surveyor identified there was lack of developing and implementing an individualized T&R program for R87 and E3 related to the Surveyor to follow-up with E2 (DON). 6/13/22 2:30 PM - An interview with the assigned CNA (E25) revealed that R87 was T&R every 2 hours with skin checks during the shift and stated that R87 has not refused to be T&R every 2 hours. 6/14/22 2:45 PM - An interview with the assigned CNA (E42) revealed that R87 was T&R every 2 hours with skin checks during the shift and stated	F 686		

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F 686	Continued From page 42 that R87 has not refused to be T&R every 2 hours. 6/14/22 1:50 PM - An interview with E2 (DON) in the presence of E1 (NHA) was conducted. E2 confirmed prior to the identification of the sacral PU on 6/1/22, R87 scored as being at "mild risk" for the development of a PU on the Braden Scale and R87 required assistance of staff for bed mobility as R87 was unable to perform this without staff assistance. At the conclusion of the interview, the Surveyor requested evidence of whether the facility developed and implemented an individualized T&R program. After the interview, E2 stated that T&R was documented in the resident's clinical record and the Surveyor informed E2 that the Surveyor had reviewed R87's clinical records, including Nursing progress notes and there was lack of evidence of an individualized T&R plan. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 and E2.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was	F 689	A. Unable to correct as R321 has been	8/10/22

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F 689	Continued From page 43 determined that for one (R321) out of eight residents reviewed for accidents, the facility failed to provide adequate supervision to prevent an accident on 11/30/21, despite having a physician's order for a 1:1 sitter at all times. Findings include: Review of R321's clinical records revealed the following: 11/10/21 - R321 was admitted to the facility for rehabilitation with diagnoses that included: hip fracture, dementia with behavioral disturbance, and abnormal gait and mobility. 11/11/21 - An event summary report documented R321 was found on the floor next to the bed with a skin tear to the elbow. 11/12/21 - A nursing progress note documented that R321 was transferred to the hospital due to an unwitnessed fall and for a brain scan as R321 takes blood thinners. 11/12/21 - An event summary report documented that R321 was found on the floor next to the bed, fall mats were in place, but R321 had a laceration to the left side of the forehead. R321 was sent to the hospital for evaluation. The facility updated R321's care plan to include wearing hipsters at all times. 11/17/21 - An event summary report documented R321 was found sitting on the floor of his room. A care plan related to falls was revised on 11/17/21, with an added intervention that an employee would provide 1:1 care at all times until discontinued by medical (Physician or Nurse	F 689	discharged from the facility. B. The Director of Nursing completed an audit on all current residents on 1:1 supervision to ensure 1:1 supervision is being provided as ordered, and appropriate documentation is completed. All residents who require 1:1 supervision have the potential to be affected by the alleged deficient practice. C. A root cause analysis was completed on 7/05/2022 determined that not all residents were being provided 1:1 supervision as ordered. In addition, 1:1 supervision documentation was either not completed consistently according to facility policy and/or not completed utilizing a standardized facility 1:1 Enhanced Supervision form. The Nurse Practice Educator/Designee will provide additional education to all staff on providing 1:1 supervision as ordered and documentation of 1:1 supervision utilizing the enhanced supervision standardized form by 8/10/2022. D. The Director of Nursing/Designee will audit (Attachment J) all residents ordered 1:1 supervision received such supervision as ordered and that the documentation for applicable residents is completed on all shifts. Audits will be completed 3 times a week for 3 weeks or until 100% compliance is achieved, then weekly for 3 weeks or until 100% compliance is achieved, and then monthly for 3 months until 100% compliance is achieved. Results of audits will be presented to the	

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F 689	Continued From page 44 Practitioner [NP]). 11/17/21 - A physicians progress note documented that R321 was placed on 1:1 with a sitter. On 11/17/21 R321 was placed on 1:1 with a sitter by the NP and an intervention that an employee would provide 1:1 care at all times until discontinued by medical. 11/20/21 11:30 AM - A progress note documented there was not a 1:1 sitter present for this shift. 11/21/21 11:44 AM - A progress note documented there was not a 1:1 sitter present for this shift. 11/26/21 - A physician progress note documented that R321 was seen for agitation. "Patient has had multiple falls has been placed on a one-to-one sitter to ensure safety patient did not have any injury from falls we will continue to follow." 11/29/21 - A physician progress note documented as a part of the diagnosis, assessment and plan, that R321 "Has had multiple falls has been placed on a one-to-one sitter to ensure safety patient did not have any injury from falls we will continue to follow closely." 11/30/22 6:50 AM - A progress note documented that R321 had a fall and skin tear to the right eyebrow measuring 2 cm in length and a skin tear to his right forearm measuring 6 cm in length. The Primary Care Provider gave an order to send R321 to the hospital for an evaluation. 11/30/21 6:50 AM - An event summary report	F 689	QAPI committee for review and any follow up needed.	

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F 689	Continued From page 45 documented that a CNA called a nurse to R321's room where he was sitting on the bed with a skin tear to the right eyebrow and right forearm. The summary of the investigation included the "Resident may have fallen by getting OOB [out of bed] without asking for assistance d/t [due to] impaired memory r/t [related to] DX {diagnosis] of dementia." There was not a 1:1 sitter with R321 when R321 fell; the facility failed to provide adequate supervision to prevent a fall and they failed to adhere to R321's physician's order for a 1:1 sitter at all times. 11/30/21 7:16 - A progress note documented that R321's spouse was notified of the fall "resulting in head injuries to R [right] upper brow and forearm." It was agreed to send the resident to the hospital for evaluation. 11/30/21 - Hospital record review revealed that R321 was admitted to the hospital. 6/22/22 - The Surveyor requested to interview E37 (NP) or E43 (Physician) and neither was available. On the morning of 6/22/22 during a discussion with E1 (NHA) about R321's fall investigation, the Surveyor requested additional information on the fall, but was told that all of the information provided was the investigation for R321's fall that occurred on 11/30/21. The investigation provided to the Surveyor included that the "Resident may have fallen when getting out of bed." The facility lacked evidence that R321 was provided adequate supervision as the plan of care instructed.	F 689		

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F 689	Continued From page 46 Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/22/22 at 3:15 PM.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R67) out of one resident reviewed for tube feeding, the facility failed to ensure placement of the tube feeding according to current standards of practice during a medication administration. Findings include:	F 693	A. Unable to correct as Resident R67 has been discharged from the facility. B. The Director of Nursing completed an audit of all residents with gastrostomy orders. All residents with gastrostomy tubes have the potential to be affected by	8/10/22

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F 693	Continued From page 47 Review of the following current standards of practice for a gastric tube (tube used to feed resident directly into the stomach and/or to administer medications) placement verification revealed that auscultation (listening) was no longer recommended: - "Auscultation verification of gastric tube placement solely by auscultation, which involves instillation of air into the tube while simultaneously listening with a stethoscope over the epigastric (abdominal) region for the sound of air, is no longer recommended." (Emergency Nurses Association, Clinical Practice Guidelines: Gastric Tube Placement Verification, 2017). - " Nurses should not use the auscultatory (air bolus) ..." (American Association of Critical-Care Nurses updates Practice Alert on feeding tube placement 4/1/16). The Facility policy for enteral (via the stomach) medication administration, last updated 6/1/21, directed staff to measure the tube from the point of entry into the skin to the end of the tube to determine whether the catheter has migrated. 11/18/19 - The following physicians order was written for R67: every shift check feeding tube for proper placement, tube length 23 CM, prior to each feeding, flush, or medication administration by measuring the length of the tube. 6/9/22 11:23 PM - A nursing progress note documented, "Every shift Check tube for proper placement prior to each feeding, flush, or medication administration by measuring the length of the tube, tube length 15 cm newly placed." 6/10/22 - R67's physicians order for the feeding	F 693	the alleged deficient practice. C. A root cause analysis was completed on 7/05/2022 and it was determined that the licensed nurse was previously trained on current procedure, but did not follow current procedure to check for placement of peg tube prior to administration of medications, feeding, and flushes. The Nurse Practice Educator/Designee will provide additional education to all current licensed nursing staff on Enteral Feeding (Attachment K) procedure by 8/10/2022. D. The Director of Nursing/Designee will observe (Attachment L) licensed nurses perform the process and procedure of checking peg tube placement prior to administration of medications, feeding, or flushes to ensure current process and procedure is being followed on all shifts. This audit will take place 3 times a week for 3 weeks or until compliance is achieved, then weekly for 3 weeks or until compliance is achieved, and then monthly for 3 months until compliance is achieved. Results of audits will be presented to the QAPI committee for review and recommendation.	

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F 693	Continued From page 48 tube was updated to check every shift for placement and tube length 15 CM, check feeding tube for proper placement prior to each feeding, flush, or medication administration by measuring the length of the tube. 6/10/22 at 10:46 AM - During an observation of medication administration through the feeding tube, E7 (RN) was observed checking for placement of R67's feeding tube by injecting 10 ml of air via a syringe connected to the feeding tube while listening with a stethoscope to R67's abdomen, then pulling back the plunger of the syringe to look for the presence of stomach contents. E7 stated, "I heard the gush, far as I know that is the way to check." During an interview on 6/10/22 at 2:26 PM, E7 (RN) confirmed that R67's feeding tube placement was not checked in accordance with the current physicians order. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/22/22 at 3:15 PM.	F 693		
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		8/10/22

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F 695	Continued From page 49 by: Based on observation, clinical record review, interviews, review of the facility's policies and procedures, and review of other facility documentation as indicated, it was determined that the facility failed to ensure that emergency equipment was available for potential accidental dislodgement for two (R7 and R67) out of two active residents in the facility reviewed for tracheostomy (trach) related care. The lack of available emergency equipment, in addition to the lack of competent trained staff in trach care posed an immediate jeopardy (IJ) situation to the residents with tracheostomies. The IJ was identified on 6/8/22 at 6:05 PM and was abated on 6/9/22 at 1:55 PM. Additionally the facility failed to ensure tracheostomy supplies were available for ordered treatments for R67. Lastly, during a random trach care observation of R7, the facility failed to ensure auscultation of R7's breath sounds at the conclusion of trach care. Findings include: EMERGENCY EQUIPMENT (SUPPLIES): Review of the facility's policy and procedure titled Tracheostomy Emergency Bedside Supplies, with a revision date of 6/1/21, stated the following emergency supplies will be kept at the resident's bedside and nursing is responsible for maintaining the supplies. Supplies include a spare trach tube with obturator (device that closes or blocks up an opening) of the same manufacturer brand and size currently used or one size smaller if the same size is not available, syringe for cuff inflation/deflation, manual resuscitation (Ambu) bag with any necessary connectors to fit the resident's trach tube.	F 695	A. R7 and R67 have emergency tracheostomy equipment located at bedside, as well as appropriate tracheostomy supplies available for ordered treatments as of 6/8/2022 by 3:15PM. B. The Director of Nursing completed an audit of all residents with orders for tracheostomies. All current residents with tracheostomies have the potential to be affected by the alleged deficient practice. C. A root cause analysis was completed on 6/8/2022 and identified that some, but not all emergency trach supplies were at the bedside of tracheostomy residents due to them not being replaced upon use. Licensed nurses will be provided with additional education on proper tracheostomy care, including immediately restoring emergency bedside supplies after using current supplies and the process for handling accidental decannulation in an effort to further minimize the risk of noncompliance. On 6/8/2022 proper emergency tracheostomy supplies were at the bedside of all appropriate residents. The Nurse Practice Educator/Designee provided additional education to 7 out of 15 registered nurses on emergency decannulation including necessary emergency equipment at bedside on 6/8/2022. The Nurse Practice Educator/Designee will provide this emergency decannulation education to all other registered nurses prior to the start of their first shift. The Nurse Practice	

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F 695	Continued From page 50 1. Review of R7's clinical record revealed the following: 8/6/21- R7 was admitted to the facility with a trach. 8/6/21 - A Physician's order stated to change the trach tube monthly with a Shiley #6 XLT size and as needed. 6/8/22 beginning at 2:29 PM - A joint observation with E5 (RN UM) was done of the emergency supplies that must be at the bedside. All supplies were observed with the exception of a replacement Shiley #6 XLT cuffless trach tube. Upon confirmation of the lack of replacement trach tube at the bedside, E5 left R7's room and returned to the room at 2:42 PM, approximately 13 minutes later with a replacement trach tube with the obturator. 6/8/22 2:39 PM - During an interview with the assigned LPN (E39), the Surveyor asked if the emergency supplies at the bedside was previously checked during the day shift and E39 stated it was not done. E39 was able to locate all of the emergency supplies and confirmed the replacement trach tube and obturator were not at the bedside. E39 proceeded to leave the room and stated she will locate E5 (RN UM). 6/8/22 3:45 PM - An interview with E12 (NPE) revealed for a resident with a trach, emergency supplies that must be at the bedside for potential accidental decannulation of a trach tube included a spare trach tube with obturator or one size smaller and a syringe. 2. Review of R67's clinical record revealed the	F 695	Educator will provide the tracheostomy care education to include necessary emergency equipment required at bedside to all licensed staff by 8/10/2022. D. The Director of Nursing/Designee will audit (Attachment M) all current residents with tracheostomies to ensure emergency equipment is at the bedside per policy 3 times a week for 3 weeks or until compliance is achieved, then weekly for 3 weeks or until compliance is achieved, and then monthly for 3 months until compliance is achieved. The Director of Nursing/Designee will audit (Attachment N) all licensed nurses for completion of tracheostomy care and emergency decannulation education 3 times a week for 3 weeks or until compliance is achieved, then weekly for 3 weeks or until compliance is achieved, and then monthly for 3 months until compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 695	Continued From page 51 following: 7/5/18 - R67 was admitted to the facility with multiple diagnoses including persistent vegetative state, brain damage, chronic respiratory failure, and a tracheostomy. a. 8/4/21- A physician's order was written for R67 to have a tracheostomy tube and Ambu bag [manual respirator] at the bedside to be checked every shift. R67's care plan for tracheostomy, last updated 5/9/22, had a goal that the resident would have no complications developed by the trach for 90 days. Some of the interventions included in the care plan included to keep the Ambu bag and extra trach tube in the resident's room. 6/8/22 2:45 PM - During screening of R67 for the initial pool, E32 (RN) was asked to show the Surveyor the emergency supplies for R67. On R67's wall near the bedside was a bag with a replacement trach tube, however, there was no Ambu bag present. From 2:45 PM to 2:48 PM, E32 searched R67's room for an Ambu bag and after three minutes, located it on the far side of R67's room in a cardboard box. E32 then stated, "There was new equipment delivered, someone must have moved it by accident." b. 2/15/22 - An order was implemented for R67's trach tube to be changed monthly and as needed. R67's care plan for tracheostomy, last updated 5/9/22, had a goal that the resident would have no complications developed by the trach for 90 days. Some of the interventions included in the care plan were as follows: tracheostomy tube	F 695		

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F 695	Continued From page 52 changed every 30 days. R67's care plan for alteration in respiratory status related to tracheostomy, last updated 5/9/22, included the intervention that the trach tube be changed per physician order. 2/9/22 11:11 AM - A note in R67's clinical record documented, "eMAR progress note: change tracheostomy tube monthly...every 1 month(s) starting on the 1st for 28 day(s). Tracheostomy tube size not available at this time. Ancillary [staff] made aware to reorder. NP made aware. Will reschedule for 2/11/2022, pending delivery. [R67's] (mother) made aware as well. No respiratory distress observed." 2/11/22 2:53 PM - A note in R67's clinical record documented, "Residents tracheostomy tube changed today as per physicians orders per monthly." 5/1/22 5:26 PM - A note in R67's clinical record documented, "No inner cannula (smaller tube for insertion into the trach tube) available to change. Trach care provided." 5/15/22 2:36 PM - A note in R67's clinical record documented, "Tracheostomy care including inner cannula and drain sponge every day and evening shift inner cannula has been cleansed none available to replace. Drain sponge changed." 5/16/22 2:57 PM - A note in R67's clinical record documented, "No inner cannula available to exchange." 5/18/22 8:57 PM - A note in R67's clinical record documented, "No inner cannula available to	F 695		

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F 695	Continued From page 53 exchange." 5/19/22 12:59 PM - A note in R67's clinical record written by E49 (RT) documented, "Talked with patients RN about tracheostomy inner cannula supply issue. No current trach inner cannula's available, but we do have [other sized] inner cannula's that fit and will not cause a patient safety concern. Discussed usage with RN and I will speak with materials manager regarding current solution." Review of the May 2022 TAR revealed the changing of R67's inner cannula was incorrectly documented as completed on 5/1/22. 6/1/22 12:06 PM - A note in R67's clinical record documented trach care including inner cannula was changed by respiratory therapist. 6/13/22 at 11:35 AM - During an observation of trach care with E32 (RN), E32 was asked if the facility always has trach supplies for R67, E32 replied, "No, but before Surveyor's came the respiratory therapist changed the order so we would have the supplies." During an interview on 6/14/22 at 9:52 AM, E6 (RN UM) confirmed that R67's tracheostomy supplies were not always available. During an interview on 6/14/22 at 10:11 AM with E51 (supply staff), it was confirmed that at times R67's trach supplies were unavailable. E51 stated it was due to "Back order because of COVID." During an interview on 6/14/22 at 10:55 AM, E2 (DON) reported that when R67's supplies are unavailable she "Will drive to our other center. Then we will call our provider and they will give us an order to change the date." E2 attributed the	F 695		

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F 695	Continued From page 54 facility's lack of supplies for R67's trach care to "back orders and one product was discontinued, we couldn't order it." 6/16/22 11:08 AM - An interview with E50 (Supervisor) for respiratory contract service it was reported that "From time to time there have not been inner cannula's." COMPETENT TRAINED STAFF: 3. 6/8/22 3:45 PM - An interview with E12 (Nurse Practice Educator - NPE) revealed that all licensed nurses at the time of orientation training and validation completed trach care and documented on the facility's "Clinical Competency Validation for Tracheostomy Care" documentation. E12 confirmed that this document did not include the steps to take during a trach dislodgement. E12 stated the last training and competency validation for trach dislodgement was conducted by a previous Contracted Respiratory Therapist and E12 would provide this information to the Surveyor as soon as possible. 6/8/22 4:45 PM - During an interview with E12 in the presence of E1 (NHA), E12 provided evidence of inservice and competency validation conducted for trach dislodgement on 6/3/21. Review of the list revealed that three (3) RNs (E5, E31 and E32) out of 15 current RNs completed training and competency validation. E12 confirmed the facility was unable to provide evidence for the remaining 12 RNs. 6/8/22 6:05 PM - During an interview with E1 and E12 (NPE), the parties were advised that the lack of emergency equipment and lack of competent trained staff for dislodgement of a trach was an	F 695		

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F 695	Continued From page 55 Immediate Jeopardy. Findings were confirmed with E1 and E12. E1 stated that the facility began the training and competency validation process within the past hour. 6/8/22 6:30 PM - The facility had evidence of training for a total of (7) RNs, including retraining of the three (3) previously trained RNs (E5, E31 and E32). 6/8/22 7:36 PM - The facility's abatement plan included: - Proper emergency trach supplies have been placed at both trach patients bedside as of approximately 3:15 PM on 6/8/22. - Out of 15 RN's on staff, 7 (seven) have already been educated on decannulation and emergency trach care. The remaining RNs will be educated on the topic prior to the start of their next scheduled shift. Any newly hired RN's or agency RN's will be educated upon starting employment at the center. - Orders were placed to ensure emergency trach supplies (i.e. Ambu bag and replacement trach supplies) are checked by nursing and tracked on the Medication Administration Record (MAR) each shift as of 3:45 PM on 6/8/22. - The facility will develop a policy and procedure for emergency decannulation by 6/9/22. 6/9/22 10:00 AM - Interviews were conducted with current nursing staff to determine they received training as outlined in the written plan. 6/9/22 10:00 AM - The facility provided a copy of the policy and procedure for emergency decannulation. 6/9/22 1:55 PM - The facility provided evidence	F 695		

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F 695	Continued From page 56 that all current RNs completed their training and the IJ was abated. Review of the facility's policy and procedure titled Tracheostomy Care, with a revision date of 7/15/21, stated upon completion of trach care, " ...33. Evaluate patient's respiratory rate, heart rate, breath sound, pulse oximetry, and cough effort." 4. 6/13/22 beginning at 11:00 AM - During a random trach care observation, E21 (RN) performed routine trach care, including suctioning of R7. E21 evaluated R7's respiratory rate, heart rate, pulse oximetry, and cough effort, however, failed to evaluate R7's breath sounds post trach care. 6/13/22 1:45 PM - An interview with E12 (NPE) confirmed that R7's breath sounds should have been auscultated after routine trach care. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of three (3)	F 697	A. Unable to correct as R87 pre and post numerical pain assessments are now	8/10/22

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F 697	Continued From page 57 residents reviewed for pain investigation, the facility failed to provide R87 with services consistent with professional standards of practice, the comprehensive person-centered care plan and R87's goals. Findings include: The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. The facility's Pain Management policy, revised on 6/1/21, stated, "... Policy. Patients will be evaluated as part of the nursing assessment process for the presence of pain upon admission/re-admission, quarterly, with change in condition or change in pain status... Pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan, and the patient's goals... Purpose. To maintain the highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain... PRACTICE STANDARDS: ... 8. Patients receiving interventions for pain will be monitored for effectiveness and side effects... 8.2 Effectiveness of PRN medications. 8.3 Ineffectiveness of routine or PRN medications including interventions, follow-up, and physician notification...". Review of R87's clinical records revealed the following:	F 697	being completed. B. The Director of Nursing completed an audit of all current residents with pain medication orders. All current residents that have potential to experience pain have the potential to be affected by the alleged deficient practice. C. Root cause analysis was completed on 7/18/2022 determined licensed nurses were not using a consistent quantitative assessment for the pre and post numerical pain evaluation assessment. The Nurse Practice Educator/Designee will provide additional education to all licensed nurses on documentation of utilizing a pre and post numerical pain evaluation assessment. This will be completed by 8/10/2022. D. The Director of Nursing/Designee will audit (Attachment O) all nursing documentation to ensure pre and post numerical pain evaluations are documented for any pain medication administered. This will be completed 3 times a week for 3 weeks or until 100% compliance is achieved, then weekly for 3 weeks or until 100% compliance is achieved, and then monthly for 3 months until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 697	Continued From page 58 5/17/22 3:24 PM - A Nursing Progress Note documented that R87 was admitted for pain management and therapy. R87 was documented as having pain during turning and repositioning with a pain rating of 10 out of 10 and at rest, seven (7) out of 10 (Zero (0) is no pain and 10 is the worst imaginable pain). 5/17/22 - The Admission Nursing Pain Assessment documented that R87 had severe pain in her lower back and right hip areas which were acute and R87 described the pain as aching and moves down the leg or arm. R87's acceptable pain goal was 4 and her current pain level was a 7. 5/17/22 - The Physician's Orders for pain management included the following: - Morphine Sulfate (MS) ER (Extended Release) tablet 15 mg by mouth two times daily. - Acetaminophen (ACTM) ER 650 mg by mouth every 8 hours as needed for mild to moderate pain 1/7. - Acetaminophen (ACTM) 650 mg by mouth every 4 hours as needed for mild pain. - Pain monitor every shift. - Baclofen Tablet 10 mg three times a day for muscle spasms. - Lidocaine 5% topical patch to lower back daily. 5/18/22 - Review of the admission history and physical completed by E43 (MD) stated during E43's evaluation, R87 was found to be in mild acute distress due to uncontrolled diffuse achiness secondary to chronic pain. 5/18/22 through 5/24/22 - The MAR revealed the following:	F 697		

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F 697	Continued From page 59 - 5/18/22 7:00 AM - 3:00 PM shift, Pain Monitoring documented a pain rating of 10. The clinical records lacked evidence of an evaluation of pain characteristics including quality, severity, location, precipitating/relieving factors and including, what interventions, if any were implemented. - 5/18/22 9:00 PM, there was a lack of evidence that the scheduled narcotic, MS ER 15 mg was administered. - 5/21/22 7:00 AM - 3:00 PM shift, Pain Monitoring documented a pain rating of 9. The clinical records lacked evidence of an evaluation of pain characteristics including quality, severity, location, precipitating/relieving factors and including, what interventions, if any were implemented. - 5/23/22 3:23 PM, R87 had a pain level of 7 and was administered ACTM 650 mg ordered for mild pain and "E" for effective was documented. The post pain rating of 4 was documented at 10:08 PM, approximately nine (9) hours after the pain medication was administered. - 5/24/22 7:00 AM - 3:00 PM shift, Pain Monitoring documented pain rating of 9. The clinical records lacked evidence of an evaluation of pain characteristics including quality, severity, location, precipitating/relieving factors and including, what interventions, if any were implemented. 5/24/22 - The Admission 5 day MDS Assessment stated R87 was independent with decision making, was receiving both scheduled and PRN	F 697		

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F 697	Continued From page 60 (as needed) pain medication and had pain at the time of the assessment. In addition, the pain was experienced frequently, had no affect on sleep, have to limit day to day activities due to the pain and experienced severe pain within the past 5 days of this assessment. 5/30/22 - The care plan for alteration in comfort related to chronic pain caused by spinal stenosis of the lumbar region of the spine had a goal that R87 would have an acceptable level of pain control. Interventions included to evaluate pain characteristics: quality, severity, location, precipitating/relieving factors, utilize pain scale, medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects and report to physician as indicated, monitor frequency of episodes of breakthrough pain to determine the need for pain med adjustment, complete pain assessment per protocol, assist resident to a position of comfort, utilizing pillows and appropriate positioning devices, and monitor for nonverbal signs of pain: increase in agitation, grimace, resistance to care. 5/30/22 through 6/8/22 - The MAR revealed the following: - 5/30/22 3:04 PM, R87 was administered ACTM arthritis pain ER 650 mg. The clinical records lacked evidence of an evaluation of pain characteristics including quality, severity, location, precipitating/relieving factors prior to the administration of the medication. In addition, a post pain evaluation was lacking. - 6/4/22 12:47 AM, R87 was administered ACTM arthritis pain ER 650 mg for hip pain 8/10. The Nursing Progress Note documented "Effective" at	F 697		

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F 697	Continued From page 61 11:10 AM, approximately 10 hours after the medication was administered. The clinical records lacked evidence of a post pain assessment utilizing the pain scale. - 6/9/22 2:55 PM, R87 complained of generalized pain 8/10 and it was documented that the pharmacological intervention was effective. The clinical records lacked evidence of a post pain assessment utilizing the pain scale. 6/8/22 11:39 AM - During an interview, R87 stated she was experiencing pain in her lower back and right hip with a pain level of 8/10. The Surveyor immediately informed E5 (RN UM) of R87's complaint of pain. 6/8/22 - A new Physician order for a different narcotic pain medication, Oxycodone 15 mg by mouth every 6 hours as needed for moderate to severe pain was ordered after the Surveyor informed E5 (RN UM) of R87's pain rating of 8/10. 6/14/22 1:35 PM - An interview with E2 (DON) in the presence of E3 (RNC) was conducted. The above dates and times of lack of evidence was reviewed and additional evidence was provided, however, E2 stated that it was her understanding that the utilization of a consistent pain scale for evaluation of pain pre and post intervention was not required, thus, "E" or effective was an acceptable standard for pain management. E2 further stated that the facility monitors pain every shift at any time during the shift and does not require documentation of what interventions were implemented and the outcome of the intervention. Thus, for the day shifts in which R87 reported a pain level of 10 on 5/18/22, 9 on 5/21/22, and 9	F 697		

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F 697	Continued From page 62 on 5/24/22, E2 confirmed that there was no requirement for the staff to comprehensively assess the pain. E2 confirmed that R87 was not administered the scheduled routine narcotic on 5/18/22. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		8/10/22

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F 758	Continued From page 63 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of facility documentation, it was determined that for one (R100) out of 39 sampled residents, the facility failed to accurately monitor the targeted behaviors for psychotropic medications (any medication capable of affecting the mind, emotions and behavior). Findings include: Review of R100's clinical record revealed the following: 3/16/20 - R100 was admitted to the facility with diagnoses that included dementia with behavioral disturbance and major depressive disorder. 8/25/20 - R100 was care planned for being at risk	F 758	A. Unable to correct at the time of the survey. Targeted behavior monitoring implemented for R100 on 7/15/2022. B. The Director of Nursing completed an audit of all residents receiving Psychotropic medications to ensure proper monitoring. All residents receiving psychotropic medications have the potential to be affected by the alleged deficient practice. C. A root cause analysis was completed on 7/15/2022 which identified that generalized behavior documentation was occurring, however there was a lack of targeted behavior monitoring for specific	

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F 758	Continued From page 64 for distressed/fluctuating mood symptoms related to major depressive disorder. R100's goal was to exhibit decreased episodes of agitation. The care plan interventions included, but were not limited to: - observing for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation; and - observing for signs/symptoms of new psychiatric disorder (e.g...frequent mood swings). 9/11/21 - R100's Quarterly MDS (Minimum Data Set) Assessment revealed that R100 had severe cognitive impairment and was able to ambulate or walk independently, requiring set up help only. In addition, R100 was exhibiting daily wandering behaviors during the review period. 9/12/21 - A progress note documented by E37 (Nurse Practitioner- NP) stated, "...(R100) seen for weight loss...agitation, tearful... she just wants to see her husband and she wishes she would just die...". 9/22/21 - A progress note documented by E37 stated, "...(R100) seen today for worsening agitation...per staff she continues with agitation, seems to be getting worse. Tried earlier this week to get out the side of the door...anxious walking the halls per staff." The assessment included: "Dementia with behavioral disturbance...with worsening agitation recently and has been slowly progressing with her dementia, confusion and behaviors...will add Depakote (used as a mood stabilizer)...she has been exit seeking will continue to follow closely." 9/22/21 - An order summary report indicated that R100 was ordered Depakote 125 mg two times a	F 758	Psychotropic medication types for residents receiving Psychotropic medications. The Nurse practice Educator/Designee will complete additional education with all current licensed nurses on documentation of targeted behaviors for any resident on a Psychotropic medication on or before 8/10/2022. D. The Director of Nursing/Designee will complete an audit (Attachment P) of all residents receiving psychotropic medications and ensure targeted behaviors are adequately documented 3 times a week for 3 weeks or until 100% compliance is achieved, then weekly for 3 weeks or until 100% compliance is achieved, and then monthly for 3 months until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 758	Continued From page 65 day for dementia with behavioral disturbance. 6/21/22 at 9:00 AM - Review of R100's September 2021 Medication Administration Record revealed a lack of evidence of the targeted depression symptoms and exit seeking behavior. 6/21/22 at 1:02 PM - An interview with E37 (NP) revealed symptoms of depression: tearfulness, wanting to to see her husband (who passed away), wishing to die, increased agitation and exit seeking behavior. There was no evidence that the facility was monitoring the targeted behaviors associated with using antipsychotic medication, including tearfulness, wanting to to see her husband (who passed away), wishing to die, increased agitation and exit seeking behavior. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 6/22/22 at approximately 3:15 PM.	F 758		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		8/10/22

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F 806	Continued From page 66 by: Based on observation, interview and record review, it was determined that for one (R111) out of two residents reviewed for food preferences, the facility failed to accommodate R111 's food preferences. Findings include: 2/21/20 - R111 was admitted to the facility. 6/8/22 at 12:24 PM - During a dining observation, R111's food tray was sitting on the overbed table untouched. 6/8/22 at 12:25 PM - When asked about her lunch, R111 shook her head and pointed at the toasted sandwich and potato salad on her tray. R111 attempted to slice the piece of toasted bread, but was not able to slice through it. R111 held her fork to pick up a cubed potato from her salad, but was not able to pierce the fork through the potato. R111 was pointing at the food and stated, "See that? The bread is so hard and it has a yellowish filling on it, I don't even know what's in it. The cubed potatoes are so hard like a rock. How do you think I can eat that?" R111 asked the Surveyor what's in the sandwich. This Surveyor read the meal ticket, "Tuna Salad for Sandwich, Potato Salad...Advance Dysphagia (difficulty swallowing) diet - chopped meats." R111 stated that she already told them (staff) that she can not eat tuna. R111 said she was upset that they were still sending her a tuna sandwich. 6/8/22 at 12:39 PM - The Surveyor notified E35 (LPN), who in turn sent E38 (CNA) to "Find out what the resident wants." E38 confirmed the bread was hard to cut as it was toasted. He further confirmed that the cubed potatoes in the salad were also hard. E38 stated, "The resident	F 806	A. Resident 111's preferences were updated to reflect a dislike for tuna salad on 6/9/22 prior to the completion of the survey. B. An audit will be conducted by the Registered Dietitian, Food Service Director, or Designee on resident preferences and reported dislikes in the Meal Tracker system by 8/10/22 (Attachment 2). All dietary staff will be educated on dysphasia advanced diets and proper preparation of potato salad by 8/10/22. All residents who receive nutrition orally have the potential to be affected by the alleged deficient practice. C. A root cause analysis was completed on 7/15/22 determined that residents who receive oral nutrition did not have accurate preferences reflected in the Meal Tracker system and the preferences were not discussed on an on-going basis to ensure any changes in preferences or dislikes. The Administrator/Designee will provide education to the Registered Dietician and Food Service Director on capturing resident food preferences upon admission and updating preferences on an on-going basis. D. Registered Dietician, Food Service Director, or Designee will check a selected sample of resident's meal tickets to ensure preferences and consistencies are followed on a weekly basis. Weekly audits (Attachment Q) will be conducted	

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F 806	Continued From page 67 can not eat the food on her tray. She can only eat soft food. I'll call the kitchen for a substitute and I will let the nurse know." 6/8/22 at 12:40 PM - In an interview, E35 stated that R111 was on an advanced dysphagia diet and could only eat soft consistency food. E35 added that she saw R111 and offered her a soft sandwich which R111 agreed to and notified the kitchen staff that R111 does not like tuna on any of her meals. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 6/22/22, at approximately 3:15 PM.	F 806	for a minimum of 3 months or until substantial compliance is achieved. Results of audits will be reviewed by the QAPI committee.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		8/10/22

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F 812	Continued From page 68 by: Based on observation and interview, it was determined that the facility failed to ensure sanitary storage of food, clean and sanitized surfaces on food preparation equipment, and maintain the correct concentration of sanitizing solution. During multiple kitchen tours on 6/7/22, the Surveyor observed the following: - 8:57 AM - A rectangular plastic food storage canister containing deli sliced ham, which was partially covered preventing protection from dust, debris, and other contaminants. - 9:05 AM- E30 (Cook) tested the sanitizer level of the solution in a red sanitizing bucket. When E30 tested the sanitizing solution, the test strip indicated that the level of chemical concentration in the bucket was not sufficient to provide proper sanitization. - 9:47 AM- Dried food debris on the blade and other areas of a meat slicer. - 9:52 AM- A large amount of loose dry cereal on a tray of covered cereal bowls stored in the pantry. - 10:03 AM- A large clear plastic food storage bucket containing liquid tea, which was completely uncovered preventing protection from dust, debris, and other contaminants. - 10:27 AM- An interview with E30 (Cook) revealed that none of the staff members working in the kitchen including E30, who was the designated PERSON IN CHARGE, during multiple tours of the kitchen, possessed a current Food Protection Manager Certification.	F 812	A. The observed ham was stored in a proper airtight container and the tea was stored with a proper lid on 6/9/22 prior to the end of survey . Facility's contracted provider, Ecolab, was contacted to fix the sanitization levels on the sanitizer dispenser on 6/9/22 prior to the end of survey, in an effort to ensure compliance. E30 completed Food Protection Manager Certification on 6/12/22 prior to the end of survey. Dried food debris was cleaned off of the slicer on 6/9/22 prior to the end of survey. The loose cereal was removed from the pantry on 6/9/22 prior to the end of the survey. B. All residents have the potential to be affected by the alleged deficient practice. It was determined that all dietary staff must be re-educated on proper food procurement, storage, preparation, and sanitation. C. Root cause analysis conducted on 7/15/22 determined that not all dietary staff were aware of state regulations and facility policy on proper food procurement, storage, preparation, and sanitation. In addition, it was determined not all dietary cooks current Food Protection Manager Certification. The Food Service Director/Designee will provide all dietary staff with additional education on proper cleaning practices of kitchen equipment, loose food particles not being present in the kitchen environment, and proper storage of food and beverages by 8/10/22. Any new dietary hires requiring Food	

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F 812	Continued From page 69 6/15/2022 8:11 AM - E1 (NHA) and E29 (Dining Services Manager) confirmed all findings.	F 812	Protection Manager Certification will be obligated to receive the necessary certification within the first 30 days of starting in the dietary department as of 6/9/22. D. Registered Dietician, Food Service Director, or Designee will complete a daily audit (Attachment R) of sanitizer solution to ensure proper compliance with sanitization levels. Registered Dietician, Food Service Director, or Designee will also complete and document a daily audit (Attachment S) to ensure all food and beverage is stored properly, and no loose food or food debris is present in the kitchen area. Audits will continue for a minimum of 3 months, and will be reviewed by the QAPI committee until substantial compliance is achieved.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		8/10/22

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F 880	Continued From page 70 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 71 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of infection control guidelines, it was determined that the facility failed to ensure proper hand hygiene was completed to prevent the spread of infection. During random medication pass and tracheostomy (trach) care observations, the facility failed to perform appropriate hand hygiene when changing gloves. Lastly, the facility failed to ensure the laundry room adhered to recommended CDC guidelines to prevent infection. Findings include: Review of the CDC "Hand Hygiene Guidance", last reviewed 1/30/2020, indicated the following: "The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: · Immediately before touching a patient; · Before performing an aseptic task (e.g.,	F 880	A. E22 and E23 were provided education on hand hygiene on 6/15/22 prior to the end of survey. Facility unable to correct previous action. E48 was provided education on the use of PPE while handling laundry on 6/22/22 prior to the end of survey. Facility unable to correct previous action B. The Director of Nursing completed an audit on a sample of staff members to ensure proper hand hygiene protocols were followed. The Administrator completed an audit on a sample of housekeeping staff handling laundry to ensure proper PPE was worn. All current residents have the potential to be affected by the alleged deficient practice. C. Root cause analysis was completed on 6/30/2022 determined that not all staff members were completing proper hand hygiene per facility policy and procedure. Root cause analysis completed on 6/30/2022 determined that not all housekeeping staff were aware to wear PPE while handling laundry. The Nurse	

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F 880	Continued From page 72 placing an indwelling device) or handling invasive medical devices; · Before moving from work on a soiled body site to a clean body site on the same patient; · After touching a patient or the patient's immediate environment; · After contact with blood, body fluids, or contaminated surfaces; · Immediately after glove removal... Healthcare facilities should require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. Core Concepts for Hand Hygiene: Clean Hands for Healthcare Personnel, instructs HCP to perform hand washing as follows: 1. Wet hands with water; 2. Apply soap; 3. Rub hands together for at least 15 seconds, covering all surfaces, focusing on fingertips and underneath fingernails; 4. Rinse under running water and dry with disposable towel; 5. Use the towel to turn off the faucet; "https://www.cdc.gov/handhygiene/providers/guideline.html." Review of the facility's policy and procedure titled IC203 Hand Hygiene, with a revision date of 11/25/20 and last review date of 11/15/21, stated to perform hand hygiene "...1.3 After any contact with blood or other body fluids, even if gloves are worn; 1.4 After patient care:..." 1. During random medication pass observations on 6/10/22 revealed the following:	F 880	Practice Educator/Designee will complete education with all staff on IC203 hand hygiene (Attachment T), as well as all laundry staff on the use of PPE while handling laundry by 8/10/2022. D. The Director of Nursing/Designee will complete daily audits (Attachment U) of hand hygiene daily for 7 days or until compliance is achieved, then weekly for 3 weeks or until compliance is achieved, and then monthly for 3 months until compliance is achieved. The Center Administrator/Designee will complete audits (Attachment V) to ensure the laundry staff is wearing proper PPE while handling laundry daily for 7 days or until compliance is achieved, then weekly for 3 weeks or until compliance is achieved, and then monthly for 3 months until compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 880	Continued From page 73 a. 6/10/22 beginning at approximately 11:05 AM - During a random medication pass observation, E22 (RN) performed a finger stick blood sugar (FSBS) on R110. Upon completing the FSBS, E22 discarded the contaminated glove, washed her hands with soap and running water for eight (8) seconds and turned off the faucet with her left bare hand, thereby contaminating her hand. b. 6/10/22 beginning at approximately 11:15 AM - During a random medication pass observation, E22 (RN) performed a FSBS on R106. Upon completing the FSBS, E22 discarded the contaminated glove, washed her hands with soap and running water for 10 seconds and turned off the faucet with the left sleeve of her shift. 6/10/22 11:18 AM - Interview with E22 (RN) immediately after the above observations confirmed the above observations. Cross-refer F695, Example #3 2. During a random trach care observation on 6/13/22 beginning at approximately 11 AM and concluding at 11:20 AM on R7, E23 (RN) changed his gloves four (4) times, proceeded to wash his hands with soap and running water for five (5) seconds each time, then turned off the faucet with his left bare hand for two (2) out of the four (4) hand washings performed, thereby contaminating his hand. 6/13/22 11:40 AM - Interview with E23 (RN) immediately after the above observations confirmed the observations. 3. Review of the CDC guidelines for Guidelines for Environmental Infection Control in Health-Care Facilities (last updated 2003)	F 880		

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F 880	Continued From page 74 indicated, "Laundry areas should have handwashing facilities readily available to workers. Laundry workers should wear appropriate personal protective equipment (e.g., gloves and protective garments) while sorting soiled fabrics and textiles. https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.html. The facility policy for personal clothing handling, last updated 3/1/18, revealed the absence of required PPE to be worn while handling soiled clothing. 6/16/22 at 10:13 AM - During an observation of the facility laundry room the following was observed: - lack of available gowns for PPE, only one pair of goggles and gloves was available. - access to handwashing sink was obstructed by a tall drying rack with clothing hanging on it. - paper towel dispenser not functioning. Immediately following the observation, E48 (laundry worker) confirmed the absence of gowns for PPE and stated, "We don't use them, we just wear gloves." E48 then demonstrated that the paper dispenser was not functioning and stated, "Sometimes it works, sometimes it doesn't, so I wash my hands in the bathroom on the floor (unit)." 6/21/22 at 11:00 AM - During a second observation of the laundry accompanied by E19 (Environmental Supervisor) and E1 (NHA), it was confirmed that the laundry room did not have PPE/gowns available for use when staff handle resident laundry and the only PPE staff wear when handling laundry is gloves. The	F 880		

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F 880	Continued From page 75 handwashing sink continued to be obstructed by the drying rack. E1 reported the batteries to the paper towel dispenser were replaced the previous Saturday, 6/18/22. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/22/22 at 3:15 PM.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and interview, it was determined that for one (R75) out of two sampled residents reviewed for antibiotic stewardship, the facility failed to implement their antibiotic stewardship program protocol for antibiotic use. Findings include: Review of the facility's policy and procedure titled Antibiotic Stewardship, with a revision date of 5/11/22, stated, "POLICY. Centers will implement an Antibiotic Stewardship Program that includes antibiotic use protocols and systems for monitoring antibiotic use...2.1.7 Infection Preventionist: 2.1.7.1 Monitors and supports antibiotic stewardship activities through rounds, review of provider orders, PCC (Point Click Care-	F 881	A. R75 was placed on the physician ordered antibiotic therapy per results of the culture and sensitivity on 5/8/22. Facility was unable to correct previous actions. B. The Director of Nursing completed an audit of all current residents with antibiotic orders. All current residents have the potential to be affected by the alleged deficient practice. C. Root cause analysis completed on 7/15/22 identified R75 was not placed on the appropriate sensitive antibiotic in a timely fashion as a result of the staff not	8/10/22

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F 881	Continued From page 76 an electronic system within the EMR) documentation and available PCC/pharmacy/lab reports;...". Cross-refer F684, Example #3 2/10/22 - R75 was admitted to the facility. 4/30/22 3:55 PM - A General Note (Nursing Progress Note) stated that R75 complained of being dizzy and a Physician's order was obtained to transfer R75 to the emergency room (ER). 4/30/22 - R75 returned from the ER and the ER visit summary stated R75 was diagnosed with a UTI. While in the ER, a urinalysis (UA) was initiated with the results of the culture and sensitivity (C&S) pending. R75 was ordered Augmentin (an antibiotic) for 10 days. There was lack of evidence of the results of the urine C&S in R75's clinical records. 5/3/22 8:17 AM - R75's UA/C&S results, dated 5/3/22, were in the Delaware Health Information Network (DHIN, a statewide health information exchange that registered healthcare providers can access). Lab results were requested by the Surveyor and provided by E2 (DON) during the survey on 6/15/22 at 12:15 PM. The UA/C&S results indicated that Augmentin was not on the list of antibiotics that was sensitive to the organism and to treat R75's UTI. 5/8/22 7:02 PM - A Physician's order by E43 (MD) was written for Cefdinir (a different antibiotic) by mouth for 10 days. 5/9/22 - A Progress Note by E4 (NP) stated,	F 881	following up on pending laboratory results. The NPE/Designee will provide additional education to management staff and medical personnel to check DHIN every 24 hours for culture and sensitivity results pending from a hospitalization and call the hospital if no results are received. The education will include the objective to document the routine 24-hour check for lab results in the medical record. This education will be completed by 8/10/2022. D. The Director of Nursing/Designee will complete an audit (Attachment G) daily for 7 days or until 100% compliance is achieved, weekly for 3 weeks or until 100% compliance is achieved, and then monthly for 3 months until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 881	Continued From page 77 "...Patient report (sic) burning with urination is slowly improving. Urine sensitivity results received and no sensitivity to Augmentin. Stop Augmentin...start Cefdinir... for 10 days. Will continue to monitor closely." 6/21/22 11:40 AM - During an interview, E12 (NPE) revealed that as the facility's Infection Control Preventionist, she has access to DHIN and was able to go into DHIN to check lab results. 6/21/22 11:45 AM - An interview with E4 (NP) confirmed that the 5/3/22 UA/C&S results revealed Augmentin was not on the list of antibiotics that were sensitive to R75's UTI and if E4 had checked the results on 5/3/22, she would have discontinued the Augmentin and reevaluated the treatment plan. The facility failed to ensure monitoring of R75's antibiotic use resulting in R75 receiving an inappropriate antibiotic (Augmentin) for 5 days and a delay starting an antibiotic that was sensitive to the bacteria. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 (NHA and E2 (DON).	F 881		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement	F 886		8/10/22

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F 886	Continued From page 78 and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms	F 886		

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F 886	Continued From page 79 consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure employee's who were not up to date with COVID-19 vaccinations were tested in accordance with County positivity rates. Additionally, the facility failed to ensure testing for up to date employees every 3-7 days in accordance with outbreak testing recommendations. Findings include: Review of the QSO 20-38 memorandum by CMS, last revised 3/10/22, indicated that LTC facility testing requirements for staff and residents, minimum testing for staff who are not up to date is twice a week when in substantial or high positivity rates. Minimum Testing Frequency of Staff who are not up to date (up to date means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible) are as follows: Low (blue) not recommended;	F 886	A. Unable to correct. E7, E52, E53, E22, E56 were not tested for COVID 19 twice weekly based on the high community transmission rate. B. All current employees and residents have the potential to be affected by the alleged deficient practice. C. A root cause analysis was completed on 7/15/2022 and identified the facility was out of compliance with testing staff that were not up to date with vaccinations based on the high community transmission rate. The Nurse Practice Educator/Designee will educate all current staff on the State of Delaware Department of Health testing guidance for long term care facilities (updated on 6/2/22) by 8/10/2022. D. The Director of Nursing/Designee will	

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F 886	Continued From page 80 Moderate (yellow) once a week; Substantial (orange) twice a week; High (red) twice a week, staff who are up to date do not need to be routinely tested. The facility policy for screening test for coronavirus - Residents and staff, last updated 4/7/22, indicated, "...Testing of staff, who are not up to date, should be based on the extent of the virus in the community...Facilities should use their community transmission level as a trigger for staff testing frequency...Substantial twice weekly. High twice weekly." Review of County positivity rates for the facility's location, indicated the area had a substantial positivity rate from 3/30/22 - 4/25/22 and a high positivity rate from 4/26/22 through the time of the exit on 6/22/22, which required testing twice a week. 1. Review of 2022 testing logs for the following employees who were not up to date with COVID-19 vaccinations revealed the following: - E7 (contract RN) was tested once a week for COVID-19 on the following dates: 4/5, 4/12, and 4/18. - E52 (contract CNA) was tested once a week for COVID-19 on the following dates: 4/6, 4/13, 4/20, 4/26. - E53 (contract CNA) was tested once a week for COVID-19 on the following dates: 4/5, 4/11, 4/25, 5/2, 5/9, 5/17, and 5/24. - E22 (RN) was tested once a week for COVID-19 on the following dates: 4/6, 4/12, 4/18,	F 886	audit (Attachment W) employee testing twice weekly for 3 weeks until 100% compliance achieved, then weekly for 3 weeks until 100% compliance achieved, and then monthly for 3 months until 100% compliance achieved. Results of audits will be presented to the QAPI committee for review.	

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F 886	Continued From page 81 4/26, 5/3, 5/9, 5/16, and 5/24. - E56 (CNA) was tested once a week for COVID-19 the following dates 4/19, 4/26, 5/17, 5/24, 5/31, 6/7, and 6/13. During an interview on 6/22/22 at 1:06 PM with E1 (NHA) and E12 (ICP), it was confirmed that staff who were not up to date were not tested twice a week in accordance with COVID-19 infection positivity rates. 2. The CDC webpage entitled, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes & Long Term Care Facilities, last updated February 2, 2022, indicated that when performing outbreak testing, perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but generally not earlier than 24 hours after the exposure, if known) and, if negative, again 5-7 days later. If additional cases are identified, testing should continue on affected unit(s) or facility wide every 3-7 days... until there are no new cases for 14 days. The facility policy for testing and management of symptomatic persons, close contacts and outbreaks, last updated 6/1/22, indicated, "Centers should continue with broad based testing... Perform testing for all patients and HCP regardless of vaccination status immediately and if negative again 5-7 days later... If additional cases are identified, testing should continue on affected units or facility wide every 3-7 days... until there are no new cases for 14 days." E55 (CNA), a COVID-19 up to date vaccinated	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 06/28/2022

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F 886	Continued From page 82 employee, worked in the facility several dates from 5/15/22 through 6/14/22 while the facility was in outbreak status. E55 was tested for COVID-19 on the following dates: 5/11 and 5/19, an 8 day span. 5/26 and 6/5, a 10 day span. 6/5 and 6/14, a 9 day span. During an interview on 6/21/22 at 12:47 PM, E12 (ICP) reported that the facility began outbreak status on 3/8/22 and "We were never really out of outbreak." Outbreak testing was still in progress at the facility on June 22, 2022. During an interview on 6/22/22 at 10:06 AM, E12 (ICP) stated the facility was "In an outbreak. We test all of the residents weekly. We test our staff too." Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON).	F 886		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 943		8/10/22

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F 943	Continued From page 83 §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, it was determined that for two (E40 and E41) out of seventeen random sampled staff members, the facility failed to ensure that the required training on abuse, neglect, and exploitation was completed. Findings include: The facility policy on Abuse Prohibition, updated 5/1/22, indicated, "The Center will implement an abuse prohibition program through the following: - Training of employees (both new employees and ongoing training for all employees). Training and reporting obligations will be provided to all employees... through orientation, Code of Conduct training, and a minimum of annually." Review of facility training records for abuse, neglect and exploitation revealed two staff members without evidence of training from March 2021 through June 2022 as follows: -E40 (CNA), E40's last training was completed on 3/1/21. -E41 (Agency CNA), E41's first day in the facility was 3/21/22. The facility lacked evidence of E41's training. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON). 6/27/22 2:03 PM - During an interview via telephone, E1 confirmed that annual training was	F 943	A. Unable to correct action as E40 and E41 are no longer employed at the Milford Center. B. An initial audit was completed by the Human Resources Representative/Designee for all current staff on Abuse/Neglect training. All current staff have the potential to be affected by the alleged deficient practice. C. Root cause analysis was completed on 7/15/2022 determined that former staff members did not receive abuse/neglect training in compliance with state regulation. All current staff members have abuse/neglect training and are compliant with abuse prohibition. The Nurse Practice Educator/Designee will continue to provide new hires with abuse prohibition education and confirm the education is completed by agency personnel prior to start date and a copy will be obtained and placed directly in their file. D. The Director of Nursing will audit (Attachment X) all employees files for abuse prohibition education weekly for 3 weeks or until compliance is achieved, then monthly for 3 months or until compliance is achieved, and then every 3 months for 2 cycles or until compliance is achieved. Results of audits will be	

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F 943	Continued From page 84 offered during orientation and electronically for annual training that can be accessed at any time by employees.	F 943	presented to the QAPI committee for review.	